TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
32	1388	2.6981	1	1	2	3	5
34	19926	5.3284	1	2	4	6	10
35	4860	3.4829	1	2	3	4	7
36	4637	1.4238	1	1	1	1	2
37	1545	3.8460	1	1	3	5	8
38	106	2.6415	1	1	2	3	5
39	1458	1.8759	1	1	1	2	4
40	1967	3.3421	1	1	2	4	7
42	3287	2.1150	1	1	1	2	4
43	84	4.0476	1	2	2	4	7
44	1346	4.9562	2	3	4	6	9
45	2489	3.4339	1	2	3	4	6
46	3035	4.5519	1	2	3	6	9
47	1196	3.1304	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2268	5.0004	1	2	4	6	10
50	2816	1.9950	1	1	1	2	3
51	275	2.8873	1	1	1	3	7
52	242	1.9463	1	1	1	2	3
53	2676	3.6214	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1548	2.8443	1	1	2	3	6
56	583	2.8405	1	1	2	3	6
57	496	4.7702	1	1	3	5	12
59	76	2.5921	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	236	4.8051	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3257	4.4473	1	2	3	5	9
64	3255	6.6224	1	2	4	8	14
65	31668	2.9110	1	1	2	4	5
66	6943	3.2093	1	2	3	4	6
67	510	3.7118	1	2	3	4	7
68	13096	4.1846	2	2	3	5	7
69	4070	3.3174	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	108	3.4259	1	2	3	4	6
72	789	3.5349	1	2	3	4	7
73	6418	4.3408	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40117	9.9090	3	5	7	12	19
76	40189	11.0696	3	5	9	14	21
77	2189	5.1092	1	2	4	7	10
78	29868	7.0817	3	5	6	9	12
79	203034	8.4200	3	4	7	10	16
80	8367	5.5711	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67396	6.9696	2	3	5	9	14
83	6816	5.4608	2	3	4	7	10
84	1499	3.2115	1	2	3	4	6
85	21440	6.5169	2	3	5	8	13
86	1715	3.7638	1	2	3	5	7
87	67211	6.2429	1	3	5	8	12
88	395665	5.2571	2	3	4	7	9
89	507777	6.1138	2	3	5	8	11
90	46106	4.3389	2	3	4	5	7
91	63	3.9683	1	2	3	5	7
92	14068	6.2258	2	3	5	8	12
93	1431	4.2851	1	2	4	6	8
94	12904	6.3868	2	3	5	8	13
95	1503	3.6334	1	2	3	4	7
96	63347	4.7647	2	3	4	6	8
97	28210	3.7386	1	2	3	5	7
98	18	4.5000	2	2	3	4	5
99	19288	3.1362	1	1	2	4	6
100	7679	2.1705	1	1	2	3	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
101	19908	4.4001	1	2	3	6	8
102	4712	2.7177	1	1	2	3	5
103	526	55.9620	9	15	38	81	125
104	32469	11.8910	3	6	10	15	22
105	28435	9.4345	4	6	7	11	17
106	3874	10.9174	5	7	9	13	18
107	96633	10.4780	5	7	9	12	17
108	5213	10.9714	3	6	9	14	21
109	66066	7.8103	4	5	7	9	13
110	58950	9.5307	2	5	8	11	18
111	6548	5.6188	2	4	6	7	8
112	80275	3.8243	1	1	3	5	8
113	45999	11.8933	3	5	9	15	23
114	8660	8.1865	2	4	7	10	16
115	14332	8.4104	2	4	7	11	16
116	270327	3.9279	1	1	3	5	8
117	3493	4.1457	1	1	3	5	9
118	6394	2.8907	1	1	2	4	6
119	1547	4.8946	1	1	3	6	11
120	36472	8.2124	1	2	5	11	18
121	168411	6.5102	2	4	5	8	12
122	83057	3.9825	1	2	4	5	7
123	41857	4.4094	1	1	2	6	10
124	144199	4.4338	1	2	3	6	8
125	69258	2.8460	1	1	2	4	6
126	5245	11.8471	3	6	9	15	23
127	720949	5.3848	2	3	4	7	10
128	13882	5.8857	3	4	5	7	9
129	4476	2.8132	1	1	1	3	7
130	93152	5.8377	2	3	5	7	10
131	26175	4.4798	1	3	4	6	7
132	166567	3.0916	1	2	2	4	6
133	7046	2.3686	1	1	2	3	4
134	32604	3.3402	1	2	3	4	6
135	7501	4.3393	1	2	3	5	8
136	1134	2.9365	1	1	2	4	6
138	203034	3.9942	1	2	3	5	8
139	74491	2.5373	1	1	2	3	5
140	89482	2.8042	1	1	2	3	5
141	85001	3.7313	1	2	3	5	7
142	40519	2.7087	1	1	2	3	5
143	173003	2.1910	1	1	2	3	4
144	77203	5.3186	1	2	4	7	11
145	6725	2.8174	1	1	2	4	5
146	12161	10.3049	5	7	9	12	17
147	2295	6.7115	3	5	7	8	10
148	142496	12.0975	5	7	10	14	21
149	16260	6.7259	4	5	6	8	10
150	22047	11.0292	4	6	9	14	19
151	4378	5.9826	2	3	6	8	11
152	4733	8.2766	3	5	7	10	14
153	1785	5.6112	3	4	5	7	8
154	32146	13.1977	4	7	10	16	25
155	5559	4.4970	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8532	5.5772	1	2	4	7	11
158	4386	2.6423	1	1	2	3	5
159	17279	4.9647	1	2	4	6	10
160	10447	2.7383	1	1	2	4	5
161	12543	4.1562	1	2	3	5	9
162	6726	1.9967	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5059	8.5274	4	5	7	10	14
165	1803	4.9434	2	3	5	6	8
166	3401	5.1541	2	3	4	6	10
167	2666	2.7817	1	2	2	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
168	1649	4.6731	1	2	3	6	10
169	857	2.4982	1	1	2	3	5
170	12092	11.1993	2	5	8	14	22
171	1053	4.7673	1	2	4	6	9
172	31897	6.9143	2	3	5	9	14
173	2312	3.7855	1	1	3	5	8
174	249000	4.8426	2	3	4	6	9
175	25202	2.9397	1	2	3	4	5
176	17587	5.2799	2	3	4	6	10
177	10522	4.4893	2	2	4	6	8
178	3593	3.1795	1	2	3	4	6
179	12330	6.1658	2	3	5	8	12
180	90227	5.3446	2	3	4	7	10
181	24379	3.4107	1	2	3	4	6
182	234882	4.3349	1	2	3	5	8
183	76735	2.9911	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4222	4.5246	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	838	3.9224	1	2	3	5	8
188	75482	5.5481	1	2	4	7	11
189	9623	3.2219	1	1	2	4	6
190	66	5.5909	1	2	4	7	9
191	9649	14.1563	4	7	10	17	28
192	834	7.0432	2	4	6	9	12
193	6497	12.6191	5	7	10	15	23
194	742	6.5660	2	4	6	8	11
195	5896	9.9910	4	6	8	12	17
196	1262	5.6830	2	4	5	7	9
197	22829	8.6119	3	5	7	10	15
198	6333	4.5173	2	3	4	6	8
199	1863	9.6334	2	5	7	13	19
200	1177	11.0110	2	4	8	14	22
201	1502	14.0752	4	6	11	18	28
202	27309	6.5861	2	3	5	8	13
203	29813	6.7010	2	3	5	9	13
204	54942	5.9723	2	3	5	7	11
205	23086	6.3271	2	3	5	8	12
206	1713	4.1004	1	2	3	5	8
207	32550	5.1222	1	2	4	6	10
208	9792	2.9086	1	1	2	4	6
209	353744	5.1342	3	3	4	6	8
210	133786	6.7558	3	4	6	8	11
211	29098	4.9011	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7866	8.3354	2	4	6	10	17
216	6023	9.5177	2	4	7	12	19
217	19595	12.5727	3	5	9	15	26
218	22521	5.2767	2	3	4	6	9
219	19288	3.1965	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17769	2.5644	1	1	2	3	5
224	7897	2.0380	1	1	2	3	4
225	5773	4.4653	1	2	3	6	9
226	5252	5.9842	1	2	4	8	12
227	4296	2.7491	1	1	2	3	5
228	2550	3.5910	1	1	2	4	8
229	1137	2.4450	1	1	2	3	5
230	2280	4.7487	1	2	3	6	10
231	10903	4.6309	1	2	3	6	10
232	527	4.0892	1	1	2	5	9
233	4814	7.4909	2	3	5	9	16
234	2558	3.4461	1	2	3	4	7
235	5355	5.0045	1	2	4	6	9
236	39188	4.9057	1	3	4	6	9
237	1699	3.5621	1	2	3	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
238	7684	8.2965	3	4	6	10	16
239	55608	6.2447	2	3	5	8	12
240	12878	6.6378	2	3	5	8	13
241	3005	4.0090	1	2	3	5	7
242	2655	6.5646	2	3	5	8	13
243	83845	4.7270	1	3	4	6	9
244	12628	4.8210	1	3	4	6	9
245	4919	3.5727	1	2	3	4	7
246	1343	3.7312	1	2	3	5	7
247	14016	3.4163	1	2	3	4	7
248	8925	4.6222	1	2	4	6	9
249	10902	3.5356	1	1	2	4	7
250	3601	4.1172	1	2	3	5	8
251	2274	2.9081	1	1	2	4	5
253	18995	4.7535	1	3	4	6	9
254	9941	3.2011	1	2	3	4	6
256	5904	5.0899	1	2	4	6	10
257	19379	2.9197	1	2	2	3	5
258	16797	2.0623	1	1	2	2	3
259	3704	2.7608	1	1	2	3	6
260	4700	1.4715	1	1	1	2	2
261	1775	2.1808	1	1	1	3	4
262	645	3.9271	1	1	3	5	8
263	25880	11.3104	3	5	8	14	22
264	3815	7.0029	2	3	5	8	13
265	4082	6.9581	1	2	4	8	14
266	2523	3.3436	1	1	2	4	7
267	240	4.0833	1	1	3	5	9
268	873	3.7537	1	1	2	4	8
269	8758	7.8451	2	3	6	10	16
270	2727	3.0983	1	1	2	4	7
271	22440	7.0501	3	4	6	8	13
272	5622	6.2757	2	3	5	7	12
273	1342	4.3644	1	2	3	5	8
274	2431	6.4825	1	3	5	8	13
275	201	3.7612	1	1	2	5	8
276	989	4.4034	1	2	4	5	8
277	83986	5.7562	2	3	5	7	10
278	27530	4.4238	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	14848	4.2196	1	2	3	5	8
281	6385	3.0641	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5325	4.7213	1	2	4	6	9
284	1773	3.1985	1	1	3	4	6
285	5979	10.5514	3	5	8	13	21
286	2145	6.6112	2	3	5	8	13
287	5999	10.4182	3	5	7	12	20
288	1972	5.7221	2	3	4	6	9
289	4787	3.0171	1	1	2	3	6
290	8532	2.4319	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4798	10.3558	2	4	8	13	21
293	318	4.9119	1	2	4	6	10
294	83797	4.7445	1	2	4	6	9
295	3416	3.8662	1	2	3	5	7
296	232852	5.2808	2	3	4	6	10
297	36465	3.5335	1	2	3	4	6
298	86	3.5116	1	1	2	4	7
299	1113	5.3998	1	2	4	7	11
300	16055	6.2361	2	3	5	8	12
301	2798	3.5647	1	2	3	4	7
302	7788	9.7017	5	6	7	11	17
303	19947	8.7442	4	5	7	10	15
304	12267	8.8996	2	4	7	11	18
305	2771	3.8964	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
306	9087	5.4264	1	2	3	7	12
307	2172	2.3596	1	1	2	3	4
308	8237	6.1412	1	2	4	8	13
309	4040	2.5252	1	1	2	3	5
310	25234	4.3353	1	2	3	5	9
311	7913	1.9368	1	1	1	2	4
312	1652	4.5745	1	1	3	6	10
313	636	2.4009	1	1	2	3	5
314	1	2.0000	2	2	2	2	2
315	28095	7.8214	1	2	5	10	17
316	93946	6.6586	2	3	5	8	13
317	787	3.1525	1	1	2	3	6
318	6040	5.9818	1	3	4	8	12
319	452	2.8496	1	1	2	4	6
320	182629	5.4053	2	3	4	7	10
321	26785	3.8728	2	2	3	5	7
322	66	3.7273	1	2	3	4	6
323	16620	3.2068	1	1	2	4	6
324	7588	1.9258	1	1	1	2	4
325	7746	3.8615	1	2	3	5	7
326	2359	2.6880	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	682	3.7097	1	2	3	5	7
329	107	2.4579	1	1	1	3	5
331	44791	5.5053	1	3	4	7	11
332	4640	3.4358	1	1	3	4	7
333	264	4.4356	1	2	3	5	10
334	14143	5.0008	3	3	4	6	8
335	10325	3.5485	2	3	3	4	5
336	46390	3.6056	1	2	3	4	7
337	30864	2.2143	1	1	2	3	3
338	2138	5.1300	1	2	3	7	12
339	1797	4.5042	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4067	3.1913	1	1	2	3	6
342	874	3.4748	1	2	2	4	7
344	4100	2.3539	1	1	1	2	5
345	1230	3.7195	1	1	2	4	8
346	4931	5.7175	1	3	4	7	11
347	370	3.1595	1	1	2	4	7
348	3080	4.1844	1	2	3	5	8
349	591	2.5296	1	1	2	3	5
350	6519	4.3806	2	2	4	5	8
352	692	3.9263	1	1	3	5	7
353	2693	7.0791	3	4	5	8	13
354	8980	5.7827	3	3	4	7	10
355	5919	3.4087	2	3	3	4	5
356	28210	2.5548	1	2	2	3	4
357	6046	8.6508	3	5	7	10	16
358	24803	4.4161	2	3	3	5	7
359	29406	2.8913	2	2	3	3	4
360	17303	3.0327	1	2	3	3	5
361	473	3.3742	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3572	3.2900	1	2	2	3	7
364	1811	3.5400	1	1	2	4	7
365	2008	7.1116	2	3	5	9	15
366	4324	6.6751	1	3	5	8	14
367	466	3.0193	1	1	2	4	6
368	2756	6.2144	2	3	5	8	12
369	2740	3.2281	1	1	2	4	6
370	1120	5.9848	3	3	4	5	9
371	1192	3.6460	2	3	3	4	5
372	847	3.2621	1	2	2	3	5
373	3838	2.1449	1	2	2	2	3
374	134	3.1716	1	2	2	3	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
375	5	4.4000	1	1	5	5	9
376	199	3.4472	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	173	2.7746	1	2	2	3	4
379	350	3.0914	1	1	2	3	6
380	87	1.8851	1	1	1	2	3
381	183	2.3005	1	1	1	3	5
382	54	1.2963	1	1	1	1	2
383	1486	3.9711	1	2	3	5	8
384	121	2.4132	1	1	2	3	5
385	1	2.0000	2	2	2	2	2
389	6	5.8333	1	5	5	7	7
390	9	3.3333	1	1	4	4	5
392	2630	9.6696	3	4	7	12	20
394	1779	6.8375	1	2	4	8	15
395	77187	4.5508	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19143	5.3427	1	2	4	7	11
398	18492	5.9583	2	3	5	7	11
399	1493	3.7173	1	2	3	5	7
400	7294	9.1058	2	3	6	11	20
401	6217	11.0227	2	5	8	14	22
402	1452	4.1887	1	1	3	5	9
403	36218	8.0041	2	3	6	10	16
404	4103	4.3359	1	2	3	6	9
406	2824	10.1331	3	5	8	13	21
407	667	4.1829	1	2	3	5	7
408	2404	7.7417	1	2	5	10	18
409	3746	6.1030	2	3	4	6	12
410	49872	3.5697	1	2	3	4	6
411	21	2.2857	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7391	7.4619	2	3	6	10	15
414	687	4.1499	1	2	3	5	9
415	42535	14.0456	4	6	11	17	28
416	213568	7.3051	2	4	6	9	14
417	41	4.7805	1	2	4	6	10
418	22297	6.0470	2	3	5	7	11
419	15835	4.9039	2	2	4	6	9
420	3029	3.6524	1	2	3	5	7
421	13089	3.9185	1	2	3	5	7
422	91	2.9890	1	1	2	4	6
423	9072	7.7017	2	3	6	9	16
424	1385	14.0072	2	5	10	17	27
425	15534	4.0610	1	2	3	5	8
426	4568	4.6421	1	2	3	6	9
427	1659	4.9458	1	2	3	6	11
428	855	6.7766	1	2	4	8	14
429	29447	6.5176	2	3	5	8	13
430	58875	8.3608	2	3	6	11	17
431	306	6.9869	1	3	5	8	13
432	438	5.2283	1	2	3	5	10
433	6312	3.1039	1	1	2	4	6
434	21675	5.1476	1	2	4	6	10
435	14502	4.3431	1	2	4	5	8
436	3279	13.5166	4	7	12	21	27
437	11570	8.9775	3	5	8	11	15
439	1183	7.4480	1	3	5	9	15
440	5298	8.9332	2	3	6	11	19
441	562	3.0498	1	1	2	4	7
442	15691	7.9084	1	3	6	10	16
443	3343	3.2767	1	1	2	4	7
444	5016	4.2845	1	2	3	5	8
445	2198	3.0100	1	1	2	4	6
447	4686	2.5378	1	1	2	3	5
448	2	1.5000	1	1	2	2	2

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
449	25965	3.6989	1	1	3	4	7
450	6281	2.0492	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22264	4.9182	1	2	3	6	10
453	4242	2.8868	1	1	2	4	5
454	5953	4.4749	1	2	3	5	9
455	974	2.6078	1	1	2	3	5
461	3446	4.5133	1	1	2	5	11
462	10911	12.2067	4	6	10	16	23
463	16562	4.2876	1	2	3	5	8
464	4467	3.1842	1	2	3	4	6
465	202	3.5693	1	1	1	4	7
466	1753	3.9395	1	1	2	4	8
467	1206	3.2629	1	1	2	4	6
468	59861	13.2552	3	6	10	17	26
471	11866	5.6302	3	3	5	6	9
473	7998	13.1317	2	3	7	19	33
475	109305	11.0583	2	5	9	15	22
476	5166	11.6465	2	6	10	15	21
477	26937	8.0048	1	3	6	10	17
478	118559	7.2875	1	3	5	9	15
479	21234	3.7671	1	2	3	5	7
480	446	23.0807	7	11	16	28	47
481	269	25.0632	11	19	23	30	40
482	6415	12.8803	4	7	10	15	23
483	42782	38.7045	14	21	32	48	70
484	392	13.2219	1	6	10	18	27
485	3148	9.0886	4	5	7	11	17
486	2027	12.1722	1	5	10	16	24
487	3604	7.3047	1	3	6	9	15
488	784	18.0982	3	7	13	23	37
489	14037	8.7084	2	3	6	11	18
490	4768	5.2685	1	2	4	7	10
491	11583	3.5480	2	2	3	4	6
492	2575	16.8287	4	5	12	27	35
493	55018	5.7173	1	3	5	7	11
494	26030	2.5108	1	1	2	3	5
495	130	15.9154	6	8	13	22	29
496	1095	10.7826	4	5	8	13	21
497	23026	6.2674	2	3	5	7	11
498	16601	3.4126	1	2	3	4	6
499	33369	4.8049	1	2	4	6	9
500	40659	2.7628	1	1	2	3	5
501	1974	10.0172	4	5	8	12	19
502	544	6.2702	3	4	5	7	11
503	5860	3.9602	1	2	3	5	7
504	121	31.1488	9	15	26	40	62
505	157	5.0446	1	1	2	6	11
506	1107	16.4625	4	7	13	22	33
507	410	9.4780	2	4	8	13	20
508	1102	7.4093	2	3	5	9	14
509	493	4.9270	1	2	3	6	11
510	1017	6.9646	2	3	5	8	15
511	301	4.7176	1	2	3	6	9
	11177104						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36506	9.2605	2	4	7	12	19
2	7109	9.8658	3	5	7	12	20

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
3	7	10.5714	1	4	12	12	14
4	6015	7.4519	1	3	5	9	16
5	98703	3.4164	1	1	2	4	7
6	377	3.1326	1	1	2	4	7
7	11683	9.7496	2	4	7	12	19
8	3373	3.1254	1	1	2	4	7
9	1698	6.1143	1	3	5	8	12
10	19098	6.5697	2	3	5	8	13
11	3155	4.0396	1	2	3	5	8
12	44239	6.2732	2	3	4	7	12
13	6486	5.1576	2	3	4	6	9
14	354510	6.0035	2	3	5	7	11
15	143996	3.7354	1	2	3	5	7
16	12049	5.9114	2	3	5	7	11
17	3303	3.3657	1	2	3	4	6
18	27014	5.4748	2	3	4	7	10
19	7911	3.7895	1	2	3	5	7
20	6115	9.9243	2	5	8	13	19
21	1409	6.8027	2	3	5	9	13
22	2567	4.9003	2	2	4	6	9
23	7637	4.1747	1	2	3	5	8
24	54321	5.0362	1	2	4	6	10
25	24173	3.3500	1	2	3	4	6
26	29	3.5862	1	1	3	4	6
27	3593	5.2931	1	1	3	7	12
28	11084	6.0999	1	3	5	8	12
29	3704	3.6126	1	2	3	5	7
30	1	13.0000	13	13	13	13	13
31	3126	4.3349	1	2	3	5	8
32	1388	2.6981	1	1	2	3	5
34	19926	5.3284	1	2	4	6	10
35	4860	3.4829	1	2	3	4	7
36	4637	1.4238	1	1	1	1	2
37	1545	3.8460	1	1	3	5	8
38	106	2.6415	1	1	2	3	5
39	1458	1.8759	1	1	1	2	4
40	1967	3.3421	1	1	2	4	7
42	3287	2.1150	1	1	1	2	4
43	84	4.0476	1	2	2	4	7
44	1346	4.9562	2	3	4	6	9
45	2489	3.4339	1	2	3	4	6
46	3035	4.5519	1	2	3	6	9
47	1196	3.1304	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2268	5.0004	1	2	4	6	10
50	2816	1.9950	1	1	1	2	3
51	275	2.8873	1	1	1	3	7
52	242	1.9463	1	1	1	2	3
53	2676	3.6214	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1548	2.8443	1	1	2	3	6
56	583	2.8405	1	1	2	3	6
57	496	4.7702	1	1	3	5	12
59	76	2.5921	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	236	4.8051	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3257	4.4473	1	2	3	5	9
64	3255	6.6224	1	2	4	8	14
65	31668	2.9110	1	1	2	4	5
66	6943	3.2093	1	2	3	4	6
67	510	3.7118	1	2	3	4	7
68	13096	4.1846	2	2	3	5	7
69	4070	3.3174	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	108	3.4259	1	2	3	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
72	789	3.5349	1	2	3	4	7
73	6418	4.3408	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40117	9.9090	3	5	7	12	19
76	40189	11.0696	3	5	9	14	21
77	2189	5.1092	1	2	4	7	10
78	29868	7.0817	3	5	6	9	12
79	203034	8.4200	3	4	7	10	16
80	8367	5.5711	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67396	6.9696	2	3	5	9	14
83	6816	5.4608	2	3	4	7	10
84	1499	3.2115	1	2	3	4	6
85	21440	6.5169	2	3	5	8	13
86	1715	3.7638	1	2	3	5	7
87	67211	6.2429	1	3	5	8	12
88	395665	5.2571	2	3	4	7	9
89	507777	6.1138	2	3	5	8	11
90	46106	4.3389	2	3	4	5	7
91	63	3.9683	1	2	3	5	7
92	14068	6.2258	2	3	5	8	12
93	1431	4.2851	1	2	4	6	8
94	12904	6.3868	2	3	5	8	13
95	1503	3.6334	1	2	3	4	7
96	63347	4.7647	2	3	4	6	8
97	28210	3.7386	1	2	3	5	7
98	18	4.5000	2	2	3	4	5
99	19288	3.1362	1	1	2	4	6
100	7679	2.1705	1	1	2	3	4
101	19908	4.4001	1	2	3	6	8
102	4712	2.7177	1	1	2	3	5
103	526	55.9620	9	15	38	81	125
104	32469	11.8910	3	6	10	15	22
105	28435	9.4345	4	6	7	11	17
106	3874	10.9174	5	7	9	13	18
107	96633	10.4780	5	7	9	12	17
108	5213	10.9714	3	6	9	14	21
109	66066	7.8103	4	5	7	9	13
110	58950	9.5307	2	5	8	11	18
111	6548	5.6188	2	4	6	7	8
112	80275	3.8243	1	1	3	5	8
113	45978	11.8914	3	5	9	15	23
114	8660	8.1865	2	4	7	10	16
115	14332	8.4104	2	4	7	11	16
116	270327	3.9279	1	1	3	5	8
117	3493	4.1457	1	1	3	5	9
118	6394	2.8907	1	1	2	4	6
119	1547	4.8946	1	1	3	6	11
120	36569	8.2082	1	2	5	11	18
121	168411	6.5102	2	4	5	8	12
122	83057	3.9825	1	2	4	5	7
123	41857	4.4094	1	1	2	6	10
124	144199	4.4338	1	2	3	6	8
125	69258	2.8460	1	1	2	4	6
126	5245	11.8471	3	6	9	15	23
127	720949	5.3848	2	3	4	7	10
128	13882	5.8857	3	4	5	7	9
129	4476	2.8132	1	1	1	3	7
130	93152	5.8377	2	3	5	7	10
131	26175	4.4798	1	3	4	6	7
132	166567	3.0916	1	2	2	4	6
133	7046	2.3686	1	1	2	3	4
134	32604	3.3402	1	2	3	4	6
135	7501	4.3393	1	2	3	5	8
136	1134	2.9365	1	1	2	4	6
138	203034	3.9942	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
139	74491	2.5373	1	1	2	3	5
140	89482	2.8042	1	1	2	3	5
141	85001	3.7313	1	2	3	5	7
142	40519	2.7087	1	1	2	3	5
143	173003	2.1910	1	1	2	3	4
144	77203	5.3186	1	2	4	7	11
145	6725	2.8174	1	1	2	4	5
146	12161	10.3049	5	7	9	12	17
147	2295	6.7115	3	5	7	8	10
148	142496	12.0975	5	7	10	14	21
149	16260	6.7259	4	5	6	8	10
150	22047	11.0292	4	6	9	14	19
151	4378	5.9826	2	3	6	8	11
152	4733	8.2766	3	5	7	10	14
153	1785	5.6112	3	4	5	7	8
154	32146	13.1977	4	7	10	16	25
155	5559	4.4970	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8532	5.5772	1	2	4	7	11
158	4386	2.6423	1	1	2	3	5
159	17279	4.9647	1	2	4	6	10
160	10447	2.7383	1	1	2	4	5
161	12543	4.1562	1	2	3	5	9
162	6726	1.9967	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5059	8.5274	4	5	7	10	14
165	1803	4.9434	2	3	5	6	8
166	3401	5.1541	2	3	4	6	10
167	2666	2.7817	1	2	2	3	5
168	1649	4.6731	1	2	3	6	10
169	857	2.4982	1	1	2	3	5
170	12092	11.1993	2	5	8	14	22
171	1053	4.7673	1	2	4	6	9
172	31897	6.9143	2	3	5	9	14
173	2312	3.7855	1	1	3	5	8
174	249000	4.8426	2	3	4	6	9
175	25202	2.9397	1	2	3	4	5
176	17587	5.2799	2	3	4	6	10
177	10522	4.4893	2	2	4	6	8
178	3593	3.1795	1	2	3	4	6
179	12330	6.1658	2	3	5	8	12
180	90227	5.3446	2	3	4	7	10
181	24379	3.4107	1	2	3	4	6
182	234882	4.3349	1	2	3	5	8
183	76735	2.9911	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4222	4.5246	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	838	3.9224	1	2	3	5	8
188	75482	5.5481	1	2	4	7	11
189	9623	3.2219	1	1	2	4	6
190	66	5.5909	1	2	4	7	9
191	9649	14.1563	4	7	10	17	28
192	834	7.0432	2	4	6	9	12
193	6497	12.6191	5	7	10	15	23
194	742	6.5660	2	4	6	8	11
195	5896	9.9910	4	6	8	12	17
196	1262	5.6830	2	4	5	7	9
197	22829	8.6119	3	5	7	10	15
198	6333	4.5173	2	3	4	6	8
199	1863	9.6334	2	5	7	13	19
200	1177	11.0110	2	4	8	14	22
201	1502	14.0752	4	6	11	18	28
202	27309	6.5861	2	3	5	8	13
203	29813	6.7010	2	3	5	9	13
204	54942	5.9723	2	3	5	7	11

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
205	23086	6.3271	2	3	5	8	12
206	1713	4.1004	1	2	3	5	8
207	32550	5.1222	1	2	4	6	10
208	9792	2.9086	1	1	2	4	6
209	353674	5.1341	3	3	4	6	8
210	133764	6.7556	3	4	6	8	11
211	29096	4.9012	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7866	8.3354	2	4	6	10	17
216	6023	9.5177	2	4	7	12	19
217	19595	12.5727	3	5	9	15	26
218	22521	5.2767	2	3	4	6	9
219	19288	3.1965	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17769	2.5644	1	1	2	3	5
224	7897	2.0380	1	1	2	3	4
225	5773	4.4653	1	2	3	6	9
226	5252	5.9842	1	2	4	8	12
227	4296	2.7491	1	1	2	3	5
228	2550	3.5910	1	1	2	4	8
229	1137	2.4450	1	1	2	3	5
230	2280	4.7487	1	2	3	6	10
231	10903	4.6309	1	2	3	6	10
232	527	4.0892	1	1	2	5	9
233	4814	7.4909	2	3	5	9	16
234	2558	3.4461	1	2	3	4	7
235	5355	5.0045	1	2	4	6	9
236	39179	4.9058	1	3	4	6	9
237	1699	3.5621	1	2	3	4	6
238	7684	8.2965	3	4	6	10	16
239	55608	6.2447	2	3	5	8	12
240	12878	6.6378	2	3	5	8	13
241	3005	4.0090	1	2	3	5	7
242	2655	6.5646	2	3	5	8	13
243	83845	4.7270	1	3	4	6	9
244	12628	4.8210	1	3	4	6	9
245	4919	3.5727	1	2	3	4	7
246	1343	3.7312	1	2	3	5	7
247	14016	3.4163	1	2	3	4	7
248	8925	4.6222	1	2	4	6	9
249	10902	3.5356	1	1	2	4	7
250	3601	4.1172	1	2	3	5	8
251	2274	2.9081	1	1	2	4	5
253	18995	4.7535	1	3	4	6	9
254	9941	3.2011	1	2	3	4	6
256	5904	5.0899	1	2	4	6	10
257	19379	2.9197	1	2	2	3	5
258	16797	2.0623	1	1	2	2	3
259	3704	2.7608	1	1	2	3	6
260	4700	1.4715	1	1	1	2	2
261	1775	2.1808	1	1	1	3	4
262	645	3.9271	1	1	3	5	8
263	25866	11.3105	3	5	8	14	22
264	3810	7.0034	2	3	5	8	13
265	4082	6.9581	1	2	4	8	14
266	2523	3.3436	1	1	2	4	7
267	240	4.0833	1	1	3	5	9
268	873	3.7537	1	1	2	4	8
269	8758	7.8451	2	3	6	10	16
270	2727	3.0983	1	1	2	4	7
271	22440	7.0501	3	4	6	8	13
272	5622	6.2757	2	3	5	7	12
273	1342	4.3644	1	2	3	5	8
274	2431	6.4825	1	3	5	8	13
275	201	3.7612	1	1	2	5	8
276	989	4.4034	1	2	4	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
277	83986	5.7562	2	3	5	7	10
278	27530	4.4238	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	14848	4.2196	1	2	3	5	8
281	6385	3.0641	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5325	4.7213	1	2	4	6	9
284	1773	3.1985	1	1	3	4	6
285	5979	10.5514	3	5	8	13	21
286	2145	6.6112	2	3	5	8	13
287	5999	10.4182	3	5	7	12	20
288	1972	5.7221	2	3	4	6	9
289	4787	3.0171	1	1	2	3	6
290	8532	2.4319	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4798	10.3558	2	4	8	13	21
293	318	4.9119	1	2	4	6	10
294	83797	4.7445	1	2	4	6	9
295	3416	3.8662	1	2	3	5	7
296	232852	5.2808	2	3	4	6	10
297	36465	3.5335	1	2	3	4	6
298	86	3.5116	1	1	2	4	7
299	1113	5.3998	1	2	4	7	11
300	16055	6.2361	2	3	5	8	12
301	2798	3.5647	1	2	3	4	7
302	7788	9.7017	5	6	7	11	17
303	19947	8.7442	4	5	7	10	15
304	12267	8.8996	2	4	7	11	18
305	2771	3.8964	1	2	3	5	7
306	9087	5.4264	1	2	3	7	12
307	2172	2.3596	1	1	2	3	4
308	8237	6.1412	1	2	4	8	13
309	4040	2.5252	1	1	2	3	5
310	25234	4.3353	1	2	3	5	9
311	7913	1.9368	1	1	1	2	4
312	1652	4.5745	1	1	3	6	10
313	636	2.4009	1	1	2	3	5
314	1	2.0000	2	2	2	2	2
315	28095	7.8214	1	2	5	10	17
316	93946	6.6586	2	3	5	8	13
317	787	3.1525	1	1	2	3	6
318	6040	5.9818	1	3	4	8	12
319	452	2.8496	1	1	2	4	6
320	182629	5.4053	2	3	4	7	10
321	26785	3.8728	2	2	3	5	7
322	66	3.7273	1	2	3	4	6
323	16620	3.2068	1	1	2	4	6
324	7588	1.9258	1	1	1	2	4
325	7746	3.8615	1	2	3	5	7
326	2359	2.6880	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	682	3.7097	1	2	3	5	7
329	107	2.4579	1	1	1	3	5
331	44791	5.5053	1	3	4	7	11
332	4640	3.4358	1	1	3	4	7
333	264	4.4356	1	2	3	5	10
334	14143	5.0008	3	3	4	6	8
335	10325	3.5485	2	3	3	4	5
336	46390	3.6056	1	2	3	4	7
337	30864	2.2143	1	1	2	3	3
338	2138	5.1300	1	2	3	7	12
339	1797	4.5042	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4067	3.1913	1	1	2	3	6
342	874	3.4748	1	2	2	4	7
344	4100	2.3539	1	1	1	2	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
345	1230	3.7195	1	1	2	4	8
346	4931	5.7175	1	3	4	7	11
347	370	3.1595	1	1	2	4	7
348	3080	4.1844	1	2	3	5	8
349	591	2.5296	1	1	2	3	5
350	6519	4.3806	2	2	4	5	8
352	692	3.9263	1	1	3	5	7
353	2693	7.0791	3	4	5	8	13
354	8980	5.7827	3	3	4	7	10
355	5919	3.4087	2	3	3	4	5
356	28210	2.5548	1	2	2	3	4
357	6046	8.6508	3	5	7	10	16
358	24803	4.4161	2	3	3	5	7
359	29406	2.8913	2	2	3	3	4
360	17303	3.0327	1	2	3	3	5
361	473	3.3742	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3572	3.2900	1	2	2	3	7
364	1811	3.5400	1	1	2	4	7
365	2008	7.1116	2	3	5	9	15
366	4324	6.6751	1	3	5	8	14
367	466	3.0193	1	1	2	4	6
368	2756	6.2144	2	3	5	8	12
369	2740	3.2281	1	1	2	4	6
370	1120	5.9848	3	3	4	5	9
371	1192	3.6460	2	3	3	4	5
372	847	3.2621	1	2	2	3	5
373	3838	2.1449	1	2	2	2	3
374	134	3.1716	1	2	2	3	4
375	5	4.4000	1	1	5	5	9
376	199	3.4472	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	173	2.7746	1	2	2	3	4
379	350	3.0914	1	1	2	3	6
380	87	1.8851	1	1	1	2	3
381	183	2.3005	1	1	1	3	5
382	54	1.2963	1	1	1	1	2
383	1486	3.9711	1	2	3	5	8
384	121	2.4132	1	1	2	3	5
385	1	2.0000	2	2	2	2	2
389	6	5.8333	1	5	5	7	7
390	9	3.3333	1	1	4	4	5
392	2630	9.6696	3	4	7	12	20
394	1779	6.8375	1	2	4	8	15
395	77187	4.5508	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19143	5.3427	1	2	4	7	11
398	18492	5.9583	2	3	5	7	11
399	1493	3.7173	1	2	3	5	7
400	7294	9.1058	2	3	6	11	20
401	6217	11.0227	2	5	8	14	22
402	1452	4.1887	1	1	3	5	9
403	36218	8.0041	2	3	6	10	16
404	4103	4.3359	1	2	3	6	9
406	2824	10.1331	3	5	8	13	21
407	667	4.1829	1	2	3	5	7
408	2404	7.7417	1	2	5	10	18
409	3746	6.1030	2	3	4	6	12
410	49872	3.5697	1	2	3	4	6
411	21	2.2857	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7391	7.4619	2	3	6	10	15
414	687	4.1499	1	2	3	5	9
415	42535	14.0456	4	6	11	17	28
416	213568	7.3051	2	4	6	9	14
417	41	4.7805	1	2	4	6	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
418	22297	6.0470	2	3	5	7	11
419	15835	4.9039	2	2	4	6	9
420	3029	3.6524	1	2	3	5	7
421	13089	3.9185	1	2	3	5	7
422	91	2.9890	1	1	2	4	6
423	9072	7.7017	2	3	6	9	16
424	1385	14.0072	2	5	10	17	27
425	15534	4.0610	1	2	3	5	8
426	4568	4.6421	1	2	3	6	9
427	1659	4.9458	1	2	3	6	11
428	855	6.7766	1	2	4	8	14
429	29435	6.5167	2	3	5	8	13
430	58875	8.3608	2	3	6	11	17
431	306	6.9869	1	3	5	8	13
432	438	5.2283	1	2	3	5	10
433	6312	3.1039	1	1	2	4	6
434	21675	5.1476	1	2	4	6	10
435	14502	4.3431	1	2	4	5	8
436	3279	13.5166	4	7	12	21	27
437	11570	8.9775	3	5	8	11	15
439	1183	7.4480	1	3	5	9	15
440	5298	8.9332	2	3	6	11	19
441	562	3.0498	1	1	2	4	7
442	15691	7.9084	1	3	6	10	16
443	3343	3.2767	1	1	2	4	7
444	5016	4.2845	1	2	3	5	8
445	2198	3.0100	1	1	2	4	6
447	4686	2.5378	1	1	2	3	5
448	2	1.5000	1	1	2	2	2
449	25965	3.6989	1	1	3	4	7
450	6281	2.0492	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22264	4.9182	1	2	3	6	10
453	4242	2.8868	1	1	2	4	5
454	5953	4.4749	1	2	3	5	9
455	974	2.6078	1	1	2	3	5
461	3446	4.5133	1	1	2	5	11
462	10911	12.2067	4	6	10	16	23
463	16562	4.2876	1	2	3	5	8
464	4467	3.1842	1	2	3	4	6
465	202	3.5693	1	1	1	4	7
466	1753	3.9395	1	1	2	4	8
467	1206	3.2629	1	1	2	4	6
468	59764	13.2659	3	6	10	17	26
471	11866	5.6302	3	3	5	6	9
473	7998	13.1317	2	3	7	19	33
475	109305	11.0583	2	5	9	15	22
476	5166	11.6465	2	6	10	15	21
477	26937	8.0048	1	3	6	10	17
478	118559	7.2875	1	3	5	9	15
479	21234	3.7671	1	2	3	5	7
480	446	23.0807	7	11	16	28	47
481	269	25.0632	11	19	23	30	40
482	6415	12.8803	4	7	10	15	23
483	42777	38.7018	14	21	32	48	70
484	392	13.2219	1	6	10	18	27
485	3148	9.0886	4	5	7	11	17
486	2027	12.1722	1	5	10	16	24
487	3604	7.3047	1	3	6	9	15
488	784	18.0982	3	7	13	23	37
489	14037	8.7084	2	3	6	11	18
490	4768	5.2685	1	2	4	7	10
491	11583	3.5480	2	2	3	4	6
492	2575	16.8287	4	5	12	27	35
493	55018	5.7173	1	3	5	7	11
494	26030	2.5108	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
495	130	15.9154	6	8	13	22	29
496	1095	10.7826	4	5	8	13	21
497	23026	6.2674	2	3	5	7	11
498	16601	3.4126	1	2	3	4	6
499	33369	4.8049	1	2	4	6	9
500	40659	2.7628	1	1	2	3	5
501	1974	10.0172	4	5	8	12	19
502	544	6.2702	3	4	5	7	11
503	5860	3.9602	1	2	3	5	7
504	121	31.1488	9	15	26	40	62
505	157	5.0446	1	1	2	6	11
506	966	16.7598	4	8	13	22	33
507	349	9.4413	2	4	8	13	19
508	599	8.5192	2	3	6	9	17
509	210	5.3000	1	2	4	7	10
510	1661	7.3323	2	3	5	9	16
511	645	5.1581	1	2	3	6	11
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 1999

State	Urban	Rural
ALABAMA	0.373	0.377
ALASKA	0.507	0.732
ARIZONA	0.368	0.536
ARKANSAS	0.478	0.452
CALFORNIA	0.369	0.472
COLORADO	0.449	0.559
CONNECTICUT	0.500	0.505
DELAWARE	0.495	0.453
DISTRICT OF COLUMBIA	0.519	.....
FLORIDA	0.378	0.387
GEORGIA	0.486	0.487
HAWAII	0.492	0.556
IDAHO	0.548	0.576
ILLINOIS	0.443	0.543
INDIANA	0.559	0.596
IOWA	0.506	0.629
KANSAS	0.420	0.627
KENTUCKY	0.491	0.515
LOUISIANA	0.430	0.495
MAINE	0.615	0.570
MARYLAND	0.764	0.821
MASSACHUSETTS	0.528	0.559
MICHIGAN	0.469	0.580
MINNESOTA	0.518	0.591
MISSISSIPPI	0.472	0.488
MISSOURI	0.423	0.506
MONTANA	0.501	0.559
NEBRASKA	0.488	0.626
NEVADA	0.296	0.474
NEW HAMPSHIRE	0.575	0.595
NEW JERSEY	0.412	.....
NEW MEXICO	0.477	0.510
NEW YORK	0.545	0.620
NORTH CAROLINA	0.536	0.506
NORTH DAKOTA	0.616	0.662
OHIO	0.521	0.565
OKLAHOMA	0.438	0.531

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 1999—Continued

State	Urban	Rural
OREGON	0.545	0.593
PENNSYLVANIA	0.407	0.531
PUERTO RICO	0.488	0.589
RHODE ISLAND	0.590	.....
SOUTH CAROLINA	0.453	0.455
SOUTH DAKOTA	0.536	0.617
TENNESSEE	0.465	0.495
TEXAS	0.415	0.517
UTAH	0.529	0.654
VERMONT	0.644	0.603
VIRGINA	0.473	0.494
WASHINGTON	0.590	0.660
WEST VIRGINIA	0.592	0.574
WISCONSIN	0.562	0.634
WYOMING	0.475	0.677

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1999

State	Ratio
ALABAMA	0.047
ALASKA	0.066
ARIZONA	0.042
ARKANSAS	0.051
CALIFORNIA	0.039
COLORADO	0.050
CONNECTICUT	0.039
DELAWARE	0.054
DISTRICT OF COLUMBIA	0.039
FLORIDA	0.046
GEORGIA	0.056
HAWAII	0.046
IDAHO	0.060

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1999—Continued

State	Ratio
ILLINOIS	0.043
INDIANA	0.059
IOWA	0.054
KANSAS	0.049
KENTUCKY	0.051
LOUISIANA	0.053
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.056
MICHIGAN	0.045
MINNESOTA	0.049
MISSISSIPPI	0.048
MISSOURI	0.048
MONTANA	0.051
NEBRASKA	0.057
NEVADA	0.031
NEW HAMPSHIRE	0.066
NEW JERSEY	0.037
NEW MEXICO	0.045
NEW YORK	0.052
NORTH CAROLINA	0.050
NORTH DAKOTA	0.075
OHIO	0.052
OKLAHOMA	0.052
OREGON	0.050
PENNSYLVANIA	0.042
PUERTO RICO	0.049
RHODE ISLAND	0.035
SOUTH CAROLINA	0.047
SOUTH DAKOTA	0.060
TENNESSEE	0.055
TEXAS	0.051
UTAH	0.054
VERMONT	0.051
VIRGINIA	0.060
WASHINGTON	0.066
WEST VIRGINIA	0.056
WISCONSIN	0.056

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1999—Continued

State	Ratio
WYOMING	0.054

Appendix A: Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being proposed in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

II. Objectives

The primary objective of the hospital inpatient prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

We believe the proposed changes would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

As has been the case in our previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2000, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

IV. Hospitals Included in and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 45 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of February 1999, we have included 4,874 hospitals in our analysis. This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 18 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Units

As of February 1999, there were 1,085 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by speciality, there were 587 psychiatric, 191 rehabilitation, 208 long-term care, 70 childrens', 19 Christian Science Sanatoria, and 10 cancer hospitals. In addition, there were 1,494 psychiatric and 901 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the target rate-of-increase ceiling is not applicable to the 36 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 2000 would be between 0 and 2.6 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

The impact on excluded hospitals and units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We estimate the total impact of these changes for FY 2000 payments compared to FY 1999 payments to be approximately a $250 million reduction. We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1998 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not

incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these proposed policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 1998 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not analyzed here. Estimated payment impacts of proposed FY 2000 changes to the capital prospective payment system are discussed below in section VII of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1996 data).
- The effects of fully removing from the wage index the costs and hours associated with teaching physicians Part A, residents, and CRNAs; and the effects of our proposal to implement the first year of a 5-year phase-out of these costs, by calculating a wage index based on 20 percent of hospitals' average hourly wages after removing the costs and hours associated with teaching physicians, residents, and CRNAs, and 80 percent of hospitals' average hourly wages with these costs included.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2000.
- The total change in payments based on FY 2000 policies relative to payments based on FY 1999 policies.

To illustrate the impacts of the FY 2000 proposed changes, our analysis begins with a FY 2000 baseline simulation model using: the FY 1999 GROUPER (version 16.0); the FY 1999 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2000 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 1999 to FY 2000. Four factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 2000 using the most recently forecasted hospital market basket increase for FY 2000 of 2.7 percent minus 1.8 percentage points. Similarly, section 1886(b)(3)(C)(ii) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals (SCHs), essential access community hospitals (EACHs) (which are treated as SCHs for payment purposes), and Medicare-dependent, small rural hospitals (MDHs) is equal to the market basket increase of 2.7 percent minus 1.8 percentage points (for an update of 0.9 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 1999 to FY 2000 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1999 that are no longer reclassified in FY 2000 may have a negative payment impact going from FY 1999 to FY 2000; conversely, hospitals not reclassified in FY 1999 that are reclassified in FY 2000 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage increase in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 1999 will be 6.2 percent of actual total DRG payments. When the FY 1999 final rule was published, we projected FY 1999 outlier payments would be 5.1 percent of total DRG plus outlier payments, and the standardized amounts were reduced correspondingly. The effects of the higher than expected outlier payments during FY 1999 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 1999 payments per case to estimated FY 2000 payments per case.

Fourth, payments per case in FY 1999 are reduced from FY 1999 for hospitals that receive the IME or the DSH adjustments. Section 1886(d)(5)(B)(ii) of the Act provides that the IME adjustment is reduced from approximately a 6.5 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio in FY 1999, to a 6.0 percent increase in FY 2000. Similarly, in accordance with section 1886(d)(5)(F)(ix) of the Act, the DSH adjustment for FY 2000 is reduced by 3 percent from what would otherwise have been paid, compared to a 2 percent reduction for FY 1999.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,874 hospitals included in the analysis. This is 100 fewer hospitals than were included in the impact analysis in the FY 1999 final rule with comment period (63 FR 41106).

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,712 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,553 hospitals located in large urban areas (populations over 1 million), and 1,160 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,162 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2000 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,790, 1,628, 1,161, and 2,085, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,772 nonteaching hospitals in our analysis, 868 teaching hospitals with fewer than 100 residents, and 234 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (151), SCHs (639), MDHs (353), and SCH and RRCs (58) shown here were not reclassified for purposes of the standardized amount. There are three SCHs that will be reclassified for the standardized amount in FY 2000 that, therefore, are not included in these rows.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1997 Medicare cost report files, if available (otherwise FY 1996 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 37 hospitals. For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 1999 and FY 2000, or for either of those 2 years, by urban and rural status. The next rows illustrate the overall number of FY 2000 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Payments Per Case]

	Number of hosps.[1]	Drg recalib.[2]	New wage date[3]	Remove GME and CRNA costs[4]	Blended wage index costs[5]	DRG & WI changes[6]	MGCRB reclassification[7]	All FY 2000 changes[8]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
(BY GEOGRAPHIC LOCATION):								
ALL HOSPITALS	4,875	0.0	0.2	0.2	0.0	0.0	0.0	−0.6
URBAN HOSPITALS	2,712	−0.1	0.1	0.2	0.0	−0.2	−0.4	−0.8
LARGE URBAN	1,552	−0.1	−0.1	0.1	0.0	−0.4	−0.5	−1.0
OTHER URBAN	1,160	−0.1	0.4	0.4	0.1	0.1	−0.3	−0.3
RURAL HOSPITALS	2,162	0.2	0.8	0.4	0.1	0.9	2.5	0.9
BED SIZE (URBAN):								
0– 99 BEDS	679	0.2	−0.1	0.3	0.1	−0.1	−0.5	−0.3
100–199 BEDS	918	0.1	0.1	0.3	0.1	0.0	−0.5	−0.3
200–299 BEDS	553	0.0	0.2	0.3	0.1	0.0	−0.4	−0.6
300–499 BEDS	423	−0.1	0.1	0.3	0.1	−0.2	−0.3	−0.8
500 OR MORE BEDS	139	−0.2	−0.1	−0.1	0.0	−0.5	−0.4	−2.0
BED SIZE (RURAL):								
0–49 BEDS	1,194	0.5	0.6	0.4	0.1	0.9	0.2	1.5
50–99 BEDS	581	0.3	0.7	0.4	0.1	0.8	0.9	1.1
100–149 BEDS	232	0.2	0.8	0.5	0.1	0.8	3.8	0.8
150–199 BEDS	85	0.1	1.0	0.4	0.1	1.0	4.3	1.1
200 OR MORE BEDS	70	0.0	0.9	0.4	0.1	0.8	4.2	0.0
URBAN BY CENSUS DIVISION:								
NEW ENGLAND	149	0.0	0.5	0.1	0.0	0.3	−0.3	−0.6
MIDDLE ATLANTIC	416	0.0	−0.5	−0.3	−0.1	−0.8	−0.4	−2.0
SOUTH ATLANTIC	401	−0.1	0.8	0.5	0.1	0.6	−0.4	0.2
EAST NORTH CENTRAL	446	−0.1	0.7	0.0	0.0	0.4	−0.4	−0.3
EAST SOUTH CENTRAL	157	−0.1	0.8	0.4	0.1	0.6	−0.4	0.1
WEST NORTH CENTRAL	183	−0.1	−0.2	0.1	0.0	−0.5	−0.4	−1.0
WEST SOUTH CENTRAL	343	0.0	−1.2	0.5	0.1	−1.4	−0.4	−2.0
MOUNTAIN	126	−0.1	0.3	0.2	0.0	0.0	−0.4	−0.3
PACIFIC	444	−0.1	−0.3	0.7	0.1	−0.4	−0.4	−0.9
PUERTO RICO	47	0.2	0.9	0.3	0.1	0.9	−0.5	0.5
RURAL BY CENSUS DIVISION:								
NEW ENGLAND	52	0.1	0.0	0.0	0.0	−0.2	2.3	0.2
MIDDLE ATLANTIC	81	0.2	−0.5	0.2	0.0	−0.5	2.2	0.0
SOUTH ATLANTIC	285	0.2	1.7	0.6	0.1	1.8	2.7	0.8
EAST NORTH CENTRAL	301	0.2	0.8	0.5	0.1	0.8	2.0	0.8
EAST SOUTH CENTRAL	270	0.3	1.6	0.6	0.1	1.8	2.5	1.8
WEST NORTH CENTRAL	490	0.2	1.2	0.2	0.0	1.2	2.3	1.6
WEST SOUTH CENTRAL	338	0.3	−1.1	0.5	0.1	−0.9	3.5	−0.2
MOUNTAIN	201	0.3	0.5	0.3	0.1	0.5	2.0	1.4
PACIFIC	139	0.2	0.4	0.5	0.1	0.4	1.9	0.4
PUERTO RICO	5	0.2	3.2	0.4	0.1	3.2	0.7	2.5
(BY PAYMENT CATEGORIES):								
URBAN HOSPITALS	2,790	−0.1	0.1	0.2	0.0	−0.1	−0.3	−0.8
LARGE URBAN	1,628	−0.1	−0.1	0.1	0.0	−0.3	−0.4	−1.0
OTHER URBAN	1,161	−0.1	0.4	0.3	0.1	0.2	−0.3	−0.2
RURAL HOSPITALS	2,085	0.2	0.8	0.4	0.1	0.8	2.2	0.9
TEACHING STATUS:								
NON-TEACHING	3,772	0.1	0.3	0.4	0.1	0.2	0.3	0.1
LESS THAN 100 RESIDENTS	868	−0.1	0.2	0.2	0.0	−0.1	−0.3	−0.6
100+ RESIDENTS	234	−0.1	−0.1	−0.1	0.0	−0.4	−0.2	−2.0
DISPROPORTIONATE SHARE HOSPITALS (DSH):								
NON–DSH	3,048	0.0	0.3	0.3	0.1	0.1	0.2	−0.3
URBAN DSH								
100 BEDS OR MORE	1,365	−0.1	0.0	0.2	0.0	−0.2	−0.3	−0.9
FEWER THAN 100 BEDS	86	0.2	−0.3	0.5	0.1	−0.2	−0.5	−0.3
RURAL DSH								
SOLE COMMUNITY (SCH)	153	0.4	0.8	0.4	0.1	1.0	−0.1	1.5
REFERRAL CENTERS (RRC)	55	0.2	1.4	0.6	0.1	1.4	4.7	1.0
OTHER RURAL DSH HOSPITALS								
100 BEDS OR MORE	57	0.3	1.4	0.6	0.1	1.6	1.1	−0.1
FEWER THAN 100 BEDS	110	0.5	1.7	0.6	0.1	2.0	0.2	2.7
URBAN TEACHING AND DSH:								
BOTH TEACHING AND DSH	703	−0.1	0.0	0.1	0.0	−0.3	−0.4	−1.0

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments Per Case]

	Number of hosps.[1]	Drg recalib.[2]	New wage date[3]	Remove GME and CRNA costs[4]	Blended wage index costs[5]	DRG & WI changes[6]	MGCRB reclassification[7]	All FY 2000 changes[8]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
TEACHING AND NO DSH	337	−0.1	0.2	0.1	0.0	−0.1	−0.3	−1.0
NO TEACHING AND DSH	748	0.0	0.1	0.5	0.1	0.0	−0.2	−0.1
NO TEACHING AND NO DSH	1,002	0.0	0.2	0.3	0.1	0.1	−0.5	−0.3
RURAL HOSPITAL TYPES:								
NONSPECIAL STATUS HOSPITALS	884	0.3	1.1	0.6	0.1	1.3	1.1	0.9
RRC	151	0.1	0.9	0.5	0.1	0.9	5.6	0.3
SCH	639	0.3	0.3	0.2	0.0	0.4	0.3	1.2
MDH	353	0.4	0.6	0.4	0.1	0.9	0.3	1.3
SCH AND RRC	58	0.1	0.3	0.2	0.0	0.2	2.2	1.4
TYPE OF OWNERSHIP:								
VOLUNTARY	2,838	0.0	0.1	0.2	0.0	−0.1	−0.1	−0.7
PROPRIETARY	743	0.0	0.1	0.4	0.1	0.0	0.0	−0.3
GOVERNMENT	1,256	0.1	0.6	0.4	0.1	0.5	0.2	−0.2
UNKNOWN	37	−0.1	−0.3	−0.4	−0.1	−0.6	−0.2	−2.0
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:								
0–25	372	0.0	−0.4	0.6	0.1	−0.5	−0.1	−2.0
25–50	1,745	−0.1	0.0	0.2	0.0	−0.3	−0.2	−1.0
50–65	1,893	0.0	0.3	0.2	0.0	0.2	0.1	−0.2
OVER 65	822	0.1	0.7	0.3	0.1	0.6	0.3	0.2
UNKNOWN	42	−0.1	−0.3	−0.4	−0.1	−0.6	−0.2	−2.0
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:								
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:								
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	373	0.1	0.6	0.4	0.1	0.5	5.6	−0.3
URBAN	55	0.0	0.1	0.5	0.1	0.0	4.1	−2.0
RURAL	318	0.1	0.8	0.4	0.1	0.7	6.3	0.5
RECLASSIFIED DURING FY 2000 ONLY	131	0.0	1.2	0.3	0.1	1.0	3.3	4.5
URBAN	30	−0.2	1.2	0.2	0.0	0.8	2.2	2.9
RURAL	101	0.2	1.1	0.4	0.1	1.2	5.4	7.3
RECLASSIFIED DURING FY 1999 ONLY	136	0.1	0.4	0.4	0.1	0.4	−0.7	−6.0
URBAN	32	−0.1	−0.1	0.4	0.1	−0.3	−0.9	−6.0
RURAL	104	0.3	1.0	0.5	0.1	1.1	−0.4	−5.0
FY 2000 RECLASSIFICATIONS:								
ALL RECLASSIFIED HOSPITALS	504	0.0	0.7	0.4	0.1	0.6	5.1	0.8
STANDARDIZED AMOUNT ONLY	65	0.2	0.6	0.5	0.1	0.7	2.7	−0.7
WAGE INDEX ONLY	393	0.0	0.8	0.4	0.1	0.6	5.5	1.0
BOTH	46	0.1	0.4	0.4	0.1	0.3	3.8	0.2
NONRECLASSIFIED	4,344	0.0	0.1	0.2	0.0	−0.1	−0.5	−0.7
ALL URBAN RECLASSIFIED	85	−0.1	0.5	0.3	0.1	0.3	3.4	−0.1
STANDARDIZED AMOUNT ONLY	13	0.1	−0.4	0.5	0.1	−0.3	0.9	−4.0
WAGE INDEX ONLY	49	−0.2	0.8	0.3	0.1	0.5	4.3	0.5
BOTH	23	0.1	−0.2	0.4	0.1	−0.2	0.4	−0.9
NONRECLASSIFIED	2,627	−0.1	0.1	0.2	0.0	−0.2	−0.6	−0.9
ALL RURAL RECLASSIFIED	419	0.1	0.8	0.4	0.1	0.8	6.1	1.4
STANDARDIZED AMOUNT ONLY	52	0.2	1.3	0.6	0.1	1.4	4.0	1.9
WAGE INDEX ONLY	344	0.1	0.7	0.4	0.1	0.7	6.0	1.3
BOTH	23	0.1	1.4	0.4	0.1	1.3	9.3	1.8
NONRECLASSIFIED	1,717	0.3	0.8	0.4	0.1	0.9	−0.4	0.9
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	0.2	0.7	0.6	0.1	0.8	−0.5	−9.0

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1998, and hospital cost report data are from reporting periods beginning in FY 1996 and FY 1997.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 1998 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1996 cost reports.

[4] This column displays the impact of completely removing the costs and hours associated with teaching physicians Part A, residents, and CRNAs from the wage index calculation.

[5] This column illustrates the payment impact of phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs, by calculating the wage index by blending 20 percent of an average hourly wage after removing these costs with 80 percent of an average hourly wage without removing these costs.

[6] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 1, 2, 3, and 4, and the FY 2000 budget neutrality factor of 0.997393.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2000 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2000. Reclassification for prior years has no bearing on the payment impacts shown here.

[8] This column shows changes in payments from FY 1999 to FY 2000. It incorporates all of the changes displayed in columns 5 and 6 (the changes displayed in columns 1, 2, and 4 are included in column 5). It also displays the impact of the FY 2000 update, changes in hospitals' reclassification status in FY 2000 compared to FY 1999, the difference in outlier payments from FY 1999 to FY 2000, and the reductions to payments through the IME and DSH adjustments taking effect during FY 2000. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 1999 DRG relative weights (GROUPER version 16) to aggregate payments using the proposed FY 2000 DRG relative weights (GROUPER version 17). Overall payments are unaffected by the DRG reclassification and recalibration. Consistent with the minor changes we are proposing for the FY 2000 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.1 percent decrease for large and other urban hospitals; a 0.2 percent increase for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for small hospitals (a 0.2 percent increase for hospitals with fewer than 100 beds), and small decreases for larger hospitals (a 0.2 percent decrease for hospitals with more than 500 beds). Among rural hospitals, small hospital categories experience the largest increases, a 0.5 percent increase for hospitals with fewer than 50 beds.

The breakdown by urban census division shows that the decrease among urban hospitals is spread across most census categories. Payments to urban hospitals in New England, the Middle Atlantic, and the West South Central census divisions are unchanged, while payments to urban hospitals in Puerto Rico rise by 0.2 percent. All rural hospital census divisions experience payment increases ranging from 0.1 percent for hospitals in New England, to 0.3 percent for hospitals in the East South Central, West South Central, and Mountain census divisions. All other divisions experience a 0.2 percent increase.

This pattern of payment increases for small hospitals and decreases for larger hospitals persists among other categories. Declines in the relative weights of several specific DRGs likely contribute to this trend. Among these DRGs, the relative weight for DRG 108 (Other Cardiothoracic Procedures), declined from 5.9764 in FY 1999 to 5.7505 in this proposed rule for FY 2000. Also, the relative weight for DRG 112 (Percutaneous Cardiovascular Procedures) declined from 1.9893 in FY 1999 to 1.9200 in this proposed rule for FY 2000. Although these cardiovascular procedures are not necessarily limited to very large hospitals, we would expect they are more likely to occur in larger hospitals. As the relative weights of DRGs predominantly occurring in large hospitals decline, the relative weights of other DRGs rise, leading to the small payment increases in hospitals less likely to be affected by the declines in the DRGs noted above.

C. Impact of Updating the Wage Data (Column 2)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2000 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 2 shows the percentage changes in payments when going from a model using the FY 1999 wage index (effective for discharges on or after March 1, 1999 (64 FR 9378)) based on FY 1995 wage data before geographic reclassifications to a model using the FY 2000 prereclassification wage index based on FY 1996 wage data.

The wage data collected on the FY 1996 cost reports is similar to the data used in the calculation of the FY 1999 wage index. For example, the wage index values used here include all physician Part A costs (direct and contracted), resident costs, and CRNA costs. Also, as in the calculation for the FY 1999 wage index, contract labor costs and hours for top management positions are included, and the overhead costs allocated to patient care areas excluded from the calculation of the wage index are excluded as well.

The results indicate that the new wage data have an overall impact of a 0.2 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 5). Rural hospitals especially appear to benefit from the update. Their payments increase by 0.8 percent. These increases are attributable to relatively large increases in the wage index values for the rural areas of particular States; Arizona, Puerto Rico, and South Carolina all had increases greater than 6 percent in their prereclassification wage index values. At the same time, several States experience large declines due to moving to the FY 1996 wage data; Massachusetts, Texas, and Utah all had decreases greater than 6 percent.

Urban hospitals as a group are not significantly affected by the updated wage data. The gains of hospitals in other urban areas (0.4 percent increase) are offset by decreases among hospitals in large urban areas (0.1 percent decrease). Urban West South Central hospitals experience a 1.0 percent decrease, largely due to a number of MSAs in Texas with prereclassified FY 2000 wage indexes that fall by 6 percent or more. We note that the wage data used for the proposed wage index are based upon the data available as of February 22, 1999, and therefore, do not reflect revision requests received by the fiscal intermediaries after February 22, 1999. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions are likely to affect the impacts shown in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year.

The largest increases are seen in the rural census divisions. Rural Puerto Rico experiences the greatest positive impact, 3.2 percent. Hospitals in three other census divisions receive positive impacts over 1.0 percent; South Atlantic at 1.7 percent, East South Central at 1.6 percent, and West North Central at 1.2 percent.

D. Impact of Removing Teaching Physicians' Part A, Residents', and CRNAs' Costs (Column 3)

As discussed in section III.C of the preamble, we are proposing to revise the calculation of the wage index by phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs. Although the proposed FY 2000 wage index is based upon a blend of 20 percent of hospitals' average hourly wages after removing these costs and 80 percent of average hourly wages calculated without removing these costs, this column displays the impacts on payments per case of completely removing these costs from the wage index calculation.

As described above in section III.C.1 of the preamble, we determined teaching physician costs by first subtracting the costs and hours attributable to teaching physicians based upon the special survey data we collected for this purpose. If these data were not available from the survey for a particular teaching hospital, 80 percent of the total physician Part A costs and hours for that hospital were removed, consistent with the recommendation of hospital (see discussion in section III.C.1 of the preamble). If a teaching hospital did not separately report its physician Part A costs on the cost report, the amount reported on Line 23, Column 1, of the Worksheet A was removed from the total wage data (as was an associated amount for hours). Resident and CRNA costs and hours were removed in their entirety, based upon the data separately attributed to these employees on the Worksheet S–3.

Column 3 shows the payment impacts of completely removing these costs, relative to wage index values calculated based on the FY 1996 wage data without removing these costs. The overall payment impact of completely removing these costs and hours from the wage index calculation would be a 0.2 percent increase in total payments (prior to applying budget neutrality). The FY 2000 proposed wage index is, however, based on a blended average hourly wage. The impacts of this blended approach are shown in column 4.

The impact of removing these costs from the wage index calculation are generally positive across the majority of hospital categories. However, examining the impacts across urban and rural census divisions indicate that urban Middle Atlantic hospitals experience a 0.3 percent decrease. This effect is attributable to the concentration of teaching hospitals in this census division. The largest positive impact occurs in the

urban Pacific census division, a 0.7 percent payment increase.

As noted above, the data used to prepare the proposed FY 2000 wage index are subject to revision. In particular, in early February 1999, we instructed the fiscal intermediaries to review the survey data on collected teaching physician costs. We have also extended the deadline for teaching hospitals to request revisions to their teaching physician survey data until June 7, 1999. The extent of these requests and the number of changes that are approved by the fiscal intermediaries may change the impacts in the final rule.

E. Impact of 5-Year Phase-Out of Teaching Physicians', Residents', and CRNA Costs (Column 4)

As described above in section III.E of this preamble, the proposed FY 2000 wage index is calculated by blending 80 percent of hospitals' average hourly wages calculated without removing teaching physician Part A, residents, or CRNA costs (and hours); and 20 percent of average hourly wages calculated after removing these costs (and hours). This constitutes the first year of a 5-year phase-out of these costs, where the proportion of the calculation based upon average hourly wages after removing these costs increases by 20 percentage points per year.

This column shows the impact of the blended wage index relative to a wage index using FY 1996 wage data without removing costs or hours of teaching physicians Part A, residents, or CRNAs. The impacts in column 4 are minimal (an increase or decrease of 0.1 percent). As expected, the hospital categories experiencing negative payment impacts in column 3 experience either negative 0.1 percent changes or no change here. The overall impact is 0.0 percent.

The combined wage index changes in Table I are determined by summing the individual impacts in columns 2 and 4. For example, the urban West South Central census division loses 1.2 percent from the new wage data, and gains 0.1 percent from the blended wage index. Therefore, the combined impact of the proposed FY 2000 wage index for these hospitals is a 1.1 percent decrease.

The following chart compares the shifts in wage index values for labor market areas for FY 2000 relative to FY 1999. This chart demonstrates the impact of the proposed changes for the FY 2000 wage index relative to the FY 1999 wage index. The majority of labor market areas (299) experience less than a 5 percent change. A total of 47 labor market areas experience an increase of more than 5 percent with 14 having an increase greater than 10 percent. A total of 28 areas experience decreases of more than 5 percent. Of those, 7 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 1999	FY 2000
Increase more than 10 percent	9	14
Increase more than 5 percent and less than 10 percent	29	33
Increase or decrease less than 5 percent	305	299
Decrease more than 5 percent and less than 10 percent	28	21
Decrease more than 10 percent	0	7

Among urban hospitals, 169 would experience an increase of between 5 and 10 percent and 40 more than 10 percent. A total of 139 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 130 urban hospitals and 187 rural hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. There are no rural hospitals with decreases greater than 10 percent, and 21 urban hospitals in this category. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	40	0
Increase more than 5 percent and less than 10 percent	169	139
Increase or decrease less than 5 percent	2352	1836
Decrease more than 5 percent and less than 10 percent	130	187
Decrease more than 10 percent	21	0

F. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 5)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 1999 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2000 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.997393. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 5. The 0.0 percent impact for All Hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 1, 2, and 4, minus approximately 0.3 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

G. Impact of MGCRB Reclassifications (Column 6)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2000. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the DSH adjustment.

Beginning in 1998, by February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. (In previous years, these determinations were made by March 30.) The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both or for FYs 1999–2001 for purposes of

qualifying for a DSH adjustment or to receive a higher DSH payment.

The proposed FY 2000 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2000. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of February 27, 1999. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2000.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.994453 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.5 percent, while payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.3 percent, while large urban hospitals lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among all rural hospital groups. The smallest increases among the rural census divisions is 0.7 percent for Puerto Rico and 1.9 percent for Pacific. The largest increase is in rural West South Central, with an increase of 3.5 percent.

Among rural hospitals designated as RRCs, 127 hospitals are reclassified for purposes of the wage index only, leading to the 5.6 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which has a 4.2 percent increase in payments.

Rural hospitals reclassified for FY 1999 and FY 2000 experience a 6.3 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 2000 only experience a 5.4 percent increase in payments, while rural hospitals reclassified for FY 1999 only experience a 0.4 percent decrease in payments. Urban hospitals reclassified for FY 1999 but not FY 2000 experience a 0.9 percent decline in payments overall. Urban hospitals reclassified for FY 2000 but not for FY 1999 experience a 3.3 percent increase in payments.

The FY 2000 Reclassification rows of Table I show the changes in payments per case for all FY 2000 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive a 9.3 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 6.0 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.1 percent for FY 2000.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.5 percent. Rural nonreclassified hospitals decrease by 0.4 percent, and urban nonreclassified hospitals lose 0.6 percent (the amount of the budget neutrality offset).

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by February 27, 1999. As previously noted, there may be changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process. The outcome of these cases will be reflected in the analysis presented in the final rule.

H. All Changes (Column 7)

Column 7 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2000 (including statutory changes), to our estimate of payments per case in FY 1999. It includes the effects of the 0.9 percent update to the standardized amounts and the hospital-specific rates for SCHs and MDHs. It also reflects the 1.1 percentage point difference between the projected outlier payments in FY 2000 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1999 (6.2 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

Additional changes affecting the difference between FY 1999 and FY 2000 payments are the reductions to the IME and DSH adjustments enacted by the Balanced Budget Act of 1997. These changes initially went into effect during FY 1998 and include additional decreases in payment for each of several succeeding years. As noted in the introduction to this impact analysis, for FY 2000, IME is reduced to approximately a 6.0 percent rate of increase, and DSH is reduced by 3 percent from what hospitals otherwise would receive. We estimate the overall effect of these statutory changes to be a 0.5 percent reduction in FY 2000 payments. For hospitals receiving both IME and DSH, the impact is estimated to be a 0.8 percent reduction in payments per case.

We also note that column 8 includes the impacts of FY 2000 MGCRB reclassifications compared to the payment impacts of FY 1999 reclassifications. Therefore, when comparing FY 2000 payments to FY 1999, the percent changes due to FY 2000 reclassifications shown in column 6 need to be offset by the effects of reclassification on hospitals' FY 1999 payments (column 7 of Table 1, July 31, 1998 final rule (63 FR 41106)). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1999 payments was approximately a 2.7 percent increase, more than offsetting the 2.5 percent increase in column 6 for FY 2000. Therefore, the net change in FY 2000 payments due to reclassification for rural hospitals is actually a decrease of 0.2 percent relative to FY 1999. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 7 may not equal the sum of the changes in columns 5 and 6, plus the other impacts that we are able to identify.

The overall payment change from FY 1999 to FY 2000 for all hospitals is a 0.6 percent decrease. This reflects the 0.9 percent update for FY 2000, the 1.1 percent lower outlier payments in FY 1999 compared to FY 1999 (5.1 percent compared to 6.2 percent); and the 0.5 percent reduction due to lower IME and DSH payments.

Hospitals in urban areas experience a 0.8 percent drop in payments per case compared to FY 1999. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 1999. The impact of reducing IME and DSH is a 0.6 percent reduction in FY 2000 payments per case. Payment to hospitals in large urban areas are expected to fall 1.0 percent per case compared to 0.3 percent per case for hospitals in other urban areas.

Hospitals in rural areas, meanwhile, experience a 0.9 percent payment increase. As discussed previously, this is primarily due to the positive effect due to the wage index and DRG changes (0.9 percent increase).

Among census divisions, urban Middle Atlantic and the West South Central display the largest negative impacts, 2.0 percent decrease in payments per case for hospitals in these two divisions. These negative impacts are primarily related to the relatively large decreases attributable to the proposed wage index. Hospitals in the South Atlantic and East South Central census divisions, along with Puerto Rico, are the only urban categories grouped by census division exhibiting increases in payments per case for FY 2000. Again, this appears to be related to the proposed FY 2000 wage index.

The only rural census division to experience a negative payment impact is West South Central (0.2 percent fall), and as is generally the case, this appears to be related to a negative payment impact related to their FY 1996 wage data. The largest increases by rural hospitals are in Puerto Rico at 2.5 percent. Among rural census divisions, the largest increases are in the East South Central and West North Central, with 1.8 percent and 1.6 percent increases in their FY 2000 payments per case, respectively. As with the other impacts discussed above, this is generally due to updating the wage data. One rural census division that did not experience an increase in payments as large

as suggested by the positive impact of updating the wage data was the South Atlantic. This census division experienced a 3.8 percent payment increase due to geographic reclassification in FY 1999, but the effect of geographic reclassification in FY 2000 was only 2.7 percent.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 1.2 percent, 1.3 percent, and 1.4 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 1999 to FY 2000 (from 6.2 of total DRG plus outlier payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

The largest negative payment impacts from FY 1999 to FY 2000 are among hospitals that were reclassified for FY 1999 and are not reclassified for FY 2000. Overall, these hospitals lose 6.0 percent. The urban hospitals in this category lose 6.0 percent, while the rural hospitals lose 5.0 percent. On the other hand, hospitals reclassified for FY 2000 that were not reclassified for FY 1999 would experience the greatest payment increases: 4.5 percent overall; 7.3 percent for 101 rural hospitals in this category and 2.9 percent for 32 urban hospitals.

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments Per Case]

	Number of hospitals	Average FY1999 payment per case	Average FY 2000 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
(BY GEOGRAPHIC LOCATION):				
ALL HOSPITALS	4,875	6,770	6,730	−0.6
URBAN HOSPITALS	2,712	7,346	7,285	−0.8
LARGE URBAN AREAS	1,552	7,879	7,787	−1.2
OTHER URBAN AREAS	1,160	6,623	6,604	−0.3
RURAL HOSPITALS	2,162	4,505	4,546	0.9
BED SIZE (URBAN):				
0–99 BEDS	679	4,973	4,957	−0.3
100–199 BEDS	918	6,165	6,147	−0.3
200–299 BEDS	553	6,998	6,958	−0.6
300–499 BEDS	423	7,803	7,741	−0.8
500 OR MORE BEDS	139	9,912	9,733	−1.8
BED SIZE (RURAL):				
0–49 BEDS	1,194	3,725	3,779	1.5
50–99 BEDS	581	4,226	4,274	1.1
100–149 BEDS	232	4,605	4,643	0.8
150–199 BEDS	85	4,930	4,983	1.1
200 OR MORE BEDS	70	5,734	5,733	0.0
URBAN BY CENSUS DIVISION:				
NEW ENGLAND	149	7,723	7,677	−0.6
MIDDLE ATLANTIC	416	8,278	8,110	−2.0
SOUTH ATLANTIC	401	6,990	7,001	0.2
EAST NORTH CENTRAL	446	6,994	6,973	−0.3
EAST SOUTH CENTRAL	157	6,579	6,586	0.1
WEST NORTH CENTRAL	183	7,053	6,981	−1.0
WEST SOUTH CENTRAL	343	6,785	6,660	−1.8
MOUNTAIN	126	7,016	6,996	−0.3
PACIFIC	444	8,460	8,388	−0.9
PUERTO RICO	47	3,108	3,124	0.5
RURAL BY CENSUS DIVISION:				
NEW ENGLAND	52	5,356	5,369	0.2
MIDDLE ATLANTIC	81	4,862	4,860	0.0
SOUTH ATLANTIC	285	4,681	4,721	0.8
EAST NORTH CENTRAL	301	4,559	4,596	0.8
EAST SOUTH CENTRAL	270	4,162	4,239	1.8
WEST NORTH CENTRAL	490	4,279	4,349	1.6
WEST SOUTH CENTRAL	338	4,002	3,993	−0.2
MOUNTAIN	201	4,751	4,817	1.4
PACIFIC	139	5,600	5,625	0.4
PUERTO RICO	5	2,334	2,392	2.5
(BY PAYMENT CATEGORIES):				
URBAN HOSPITALS	2,790	7,310	7,251	−0.8
LARGE URBAN	1,628	7,806	7,715	−1.2
OTHER URBAN	1,161	6,610	6,596	−0.2
RURAL HOSPITALS	2,085	4,480	4,519	0.9
TEACHING STATUS:				
NON-TEACHING	3,772	5,473	5,477	0.1
FEWER THAN 100 RESIDENTS	868	7,184	7,138	−0.6
100 OR MORE RESIDENTS	234	10,858	10,658	−1.8
DISPROPORTIONATE SHARE HOSPITALS (DSH):				

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments Per Case]

	Number of hospitals	Average FY1999 payment per case	Average FY 2000 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
NON-DSH	3,048	5,792	5,775	−0.3
URBAN DSH:				
100 BEDS OR MORE	1,365	7,972	7,900	−0.9
FEWER THAN 100 BEDS	86	5,193	5,180	−0.3
RURAL DSH:				
SOLE COMMUNITY (SCH):	153	4,205	4,266	1.5
REFERRAL CENTERS (RRC)	55	5,357	5,408	1.0
OTHER RURAL DSH HOSPITALS:				
100 BEDS OR MORE	57	4,186	4,183	−0.1
FEWER THAN 100 BEDS	110	3,597	3,692	2.7
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	703	8,936	8,826	−1.2
TEACHING AND NO DSH	337	7,281	7,211	−1.0
NO TEACHING AND DSH	748	6,371	6,362	−0.1
NO TEACHING AND NO DSH	1,002	5,646	5,630	−0.3
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	884	3,964	3,997	0.9
RRC	151	5,225	5,243	0.3
SCH	639	4,470	4,524	1.2
MDH	353	3,757	3,805	1.3
SCH AND RRC	58	5,368	5,442	1.4
TYPE OF OWNERSHIP:				
VOLUNTARY	2,838	6,943	6,895	−0.7
PROPRIETARY	743	6,202	6,181	−0.3
GOVERNMENT	1,256	6,286	6,273	−0.2
UNKNOWN	37	9,806	9,626	−1.8
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	372	8,826	8,692	−1.5
25–50	1,745	7,924	7,844	−1.0
50–65	1,893	5,997	5,986	−0.2
OVER 65	822	5,272	5,285	0.2
UNKNOWN	42	9,716	9,539	−1.8
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:				
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	373	5,819	5,803	−0.3
URBAN	55	8,004	7,849	−1.9
RURAL	318	5,202	5,226	0.5
RECLASSIFIED DURING FY 2000 ONLY	131	6,183	6,459	4.5
URBAN	30	8,096	8,327	2.9
RURAL	101	4,362	4,682	7.3
RECLASSIFIED DURING FY 1999 ONLY	136	5,577	5,267	−5.6
URBAN	32	6,976	6,568	−5.8
RURAL	104	4,611	4,369	−5.3
FY 2000 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSPITALS	504	5,896	5,943	0.8
STANDARDIZED AMOUNT ONLY	65	4,764	4,732	−0.7
WAGE INDEX ONLY	393	5,981	6,041	1.0
BOTH	46	6,156	6,168	0.2
NONRECLASSIFIED	4,344	6,889	6,839	−0.7
ALL URBAN RECLASSIFIED	85	8,039	8,028	−0.1
STANDARDIZED AMOUNT ONLY	13	5,253	5,032	−4.2
WAGE INDEX ONLY	49	8,867	8,908	0.5
BOTH	23	6,894	6,834	−0.9
NONRECLASSIFIED	2,627	7,318	7,255	−0.9
ALL RURAL RECLASSIFIED	419	5,075	5,144	1.4
STANDARDIZED AMOUNT ONLY	52	4,468	4,551	1.9
WAGE INDEX ONLY	344	5,110	5,175	1.3
BOTH	23	5,281	5,379	1.8
NONRECLASSIFIED	1,717	4,108	4,143	0.9
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	4,781	4,361	−8.8

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the proposed changes for FY 2000 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments per case for FY 2000 with the average estimated per case payments for FY 1999, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 7 of Table I.

VII. Impact of Proposed Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 5th and 6th years of the capital prospective payment system (cost reports beginning in FY 1996 and in FY 1997) available through the December 1998 update of the HCRIS. We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example, in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.
- Our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 2000 capital cost projections. In Appendix B of this proposed rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2000 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 2000. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the proposed FY 2000 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We continue to be unable to predict accurately FY 2000 capital costs for individual hospitals, but with the most recent data hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the Proposed FY 2000 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1999 to FY 2000 using a capital cost model. The FY 2000 model, as described in Appendix B of this proposed rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1997 as reported on the December 1998 update of HCRIS, interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through January 1, 1999 in the provider-specific file. We used these data to determine the proposed FY 2000 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1997, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1997. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the proposed FY 2000 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1998	−0.71
1999	−0.15
2000	0.75

- The Medicare case-mix index will increase by 1.0 percent in FY 1999 and 0.5 percent in FY 2000.
- The Federal capital rate and hospital-specific rate were updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs, and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2000 update is −0.6 percent (see section IV of the Addendum to this proposed rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1999 to FY 2000. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2000

Type of Hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	61	54	59
High Cost Hospital	34	39	46	41

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital into use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 1999 to FY 2000 using the above described actuarial model. With the proposed Federal rate, we estimate aggregate Medicare capital payments will increase by 2.66 percent in FY 2000.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 2000 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 1999
FY 1999 Payments per Discharge:									
Low Cost Hospitals	3,200	6,737,171	$521.48	81.42	$58.83	$3.46	$8.72	$592.49	
Fully Prospective	2,977	6,138,720	511.78	80.00	64.57	.....	8.44	584.79	.....
100% Federal Rate	193	538,418	642.90	100.00	.....	.....	4.44	647.34	.....
Hold Harmless	30	60,033	423.55	60.65	.....	388.55	75.12	887.21	.....
High Cost Hospitals	1,634	4,248,111	658.19	97.70	.....	22.81	14.66	695.65	.....
100% Federal Rate	1,424	3,876,299	677.27	100.00	.....	.....	7.26	684.53	.....
Hold Harmless	210	371,812	459.27	72.18	.....	260.63	91.71	811.60	.....
Total Hospitals	4,834	10,985,282	574.34	87.91	36.08	10.94	11.01	632.38	.....
FY 2000 Payments per Discharge:									
Low Cost Hospitals	3,200	6,785,508	573.45	90.60	29.15	2.91	10.29	615.79	3.93
Fully Prospective	2,977	6,182,772	569.26	90.00	31.99	.....	9.24	610.48	4.39
100% Federal Rate	194	543,519	632.85	100.00	.....	.....	4.51	637.36	−1.54
Hold Harmless	29	59,217	465.60	68.51	.....	333.70	173.36	972.66	9.63
High Cost Hospitals	1,634	4,278,443	649.22	98.47	.....	16.61	24.44	690.27	−0.77
100% Federal Rate	1,442	3,951,867	663.34	100.00	.....	.....	11.28	674.62	−1.45
Hold Harmless	192	326,576	478.35	78.33	.....	217.65	183.66	879.66	8.38
Total Hospitals	4,834	11,063,951	602.75	93.72	17.87	8.21	15.76	644.59	1.93

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 4.39 percent, and high capital cost hospitals will experience an average decrease of 0.77 percent. These results are due to the change in the blended percentages to the payment system to 90 percent adjusted Federal rate and 10 percent hospital-specific rate.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 80 percent to 90 percent and the hospital-specific rate payment percentage will decrease from 20 to 10 percent in FY 2000. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 72.18 percent to 78.83 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 87.1 percent to 88.2 percent. We estimate that the few remaining high cost hold-harmless hospitals (192) will experience an increase in payments of 8.38 percent from FY 1999 to FY 2000. The increase occurs because we estimate that exception payments per discharge will increase 50.1 percent from FY 1999 to FY 2000 for high cost hold-harmless hospitals. While we estimate that this group's regular hold-harmless payments for old capital will decline by 16.5 percent due to the retirement of old capital, we estimate that its high overall capital costs will cause an increase in these hospitals' exceptions payments from $91.71 per discharge in FY 1999 to $183.66 per discharge in FY 2000. This is primarily due to the estimated decrease in outlier payments, which will cause an estimated increase in exceptions payments to cover unmet capital costs.

We expect that the average hospital-specific rate payment per discharge will decrease from $64.57 in FY 1999 to $31.99 in FY 2000. This is mostly due to the decrease in the hospital-specific rate payment percentage from 20 percent in FY 1999 to 10 percent in FY 2000.

We are proposing no changes in our exceptions policies for FY 2000. As a result, the minimum payment levels would be—

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.74 percent of total capital payments in FY 1999 to 2.45 percent of payments in FY 2000. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2000 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	180	40
High Capital Cost	208	60
Total	388	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total number of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,834	4.6	33.8	61.6
Large urban areas (populations over 1 million)	1,531	4.8	41.7	53.4
Other urban areas (populations of 1 million of fewer)	1,146	5.7	42.0	52.4
Rural areas	2,157	3.8	23.9	72.3
Urban hospitals	2,677	5.2	41.8	53.0
0–99 beds	650	6.5	34.3	59.2
100–199 beds	912	7.2	48.5	44.3
200–299 beds	553	4.2	42.3	53.5
300–499 beds	423	1.4	39.2	59.3
500 or more beds	139	1.4	39.6	59.0
Rural hospitals	2,157	3.8	23.9	72.3
0–49 beds	1,190	3.4	16.8	79.7
50–99 beds	580	4.5	29.5	66.0
100–149 beds	232	4.7	36.6	58.6
150–199 beds	85	3.5	30.6	65.9
200 or more beds	70	1.4	48.6	50.0
By Region:				
Urban by Region	2,677	5.2	41.8	53.0
New England	148	0.7	28.4	70.9
Middle Atlantic	412	2.7	36.4	60.9
South Atlantic	399	5.3	52.9	41.9
East North Central	444	6.1	31.8	62.2
East South Central	154	10.4	46.8	42.9
West North Central	179	3.4	40.2	56.4
West South Central	331	10.3	59.2	30.5
Mountain	123	5.7	50.4	43.9
Pacific	440	3.4	36.6	60.0
Puerto Rico	47	2.1	27.7	70.2
Rural by Region	2,157	3.8	23.9	72.3
New England	52	1.9	23.1	75.0
Middle Atlantic	80	6.3	20.0	73.8
South Atlantic	285	1.4	34.7	63.9
East North Central	300	3.3	18.3	78.3
East South Central	270	2.6	34.1	63.3
West North Central	490	3.7	15.9	80.4
West South Central	337	3.9	27.9	68.2
Mountain	200	8.5	18.0	73.5
Pacific	138	5.1	23.9	71.0
By Payment Classification:				
Large urban areas (populations over 1 million)	1,607	4.7	41.8	53.6
Other urban areas (populations of 1 million of fewer)	1,147	5.8	41.3	52.9
Rural areas	2,080	3.8	23.6	72.5
Teaching Status:				
Non-teaching	3,732	5.0	33.1	61.9
Fewer than 100 Residents	868	3.8	37.0	59.2
100 or more Residents	234	1.3	33.3	65.4

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total number of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Disproportionate share hospitals (DSH):.				
Non-DSH	3,014	4.6	29.9	65.5
Urban DSH:				
100 or more beds	1,362	4.4	44.6	51.0
Less than 100 beds	84	8.3	23.8	67.9
Rural DSH:				
Sole Community (SCH)	153	5.9	20.9	73.2
Referral Center (RRC)	55	3.6	43.6	52.7
Other Rural:.				
100 or more beds	57	1.8	43.9	54.4
Less than 100 beds	109	2.8	25.7	71.6
Urban teaching and DSH:				
Both teaching and DSH	703	2.7	37.7	59.6
Teaching and no DSH	337	4.5	33.8	61.7
No teaching and DSH	743	6.5	48.7	44.8
No teaching and no DSH	971	6.1	41.6	52.3
Rural Hospital Types:				
Non special status hospitals	881	1.7	25.0	73.3
RRC/EACH	151	0.7	43.0	56.3
SCH/EACH	638	7.7	21.0	71.3
Medicare-dependent hospitals (MDH)	352	2.3	16.2	81.5
SCH, RRC and EACH	58	12.1	25.9	62.1
Type of Ownership:				
Voluntary	2,826	4.0	33.4	62.6
Proprietary	721	7.6	59.1	33.3
Government	1,255	3.8	20.8	75.4
Medicare Utilization as a Percent of Inpatient Days:				
0–25	360	4.4	27.8	67.8
25–50	1,739	4.8	36.6	58.7
50–65	1,885	4.2	33.3	62.5
Over 65	817	4.7	32.9	62.4

As we explain in Appendix B of this proposed rule, we were not able to determine a hospital-specific rate for 40 of the 4,874 hospitals in our database. Consequently, the payment methodology distribution is based on 4,834 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) Geographic location; (2) region; and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 33.8 percent in FY 2000.

Table IV indicates that 61.6 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the chart on ''Capital Transition Payment Methodology for FY 2000,'' in section VII.B.2. of this preamble takes into account the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (72.5 percent and 75.4 percent, respectively by payment classification) are being paid under the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 33.3 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2000 actuarial model to estimate the potential impact of our proposed changes for FY 2000 on total capital payments per case, using a universe of 4,834 hospitals. The individual hospital payment parameters are taken from the best available data, including: the January 1, 1999 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the proposed FY 2000 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 1999 and FY 2000. Column 5 shows the total percentage change in payments from FY 1999 to FY 2000. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.0 percent decrease in the Federal rate, a 0.5 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects

of all other changes, including the change from 80 percent to 90 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 1.9 percent in FY 2000, despite the effect of the 1.4 percent decrease attributable to the reduction in the Federal rate and other factors (which include changes in the adjustment to the Federal rate, the increase in case mix, and the other components of column 6 of table V).

Our comparison by geographic location shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (1.8 percent and 2.8 percent, respectively). This difference is due to the higher rate of decrease for urban hospitals relative to rural hospitals (1.6 percent and 0.4 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.4 percent versus 3.2 percent) from the effects of all other changes.

Most regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 80 to 90 percent). Changes by region vary from a low of 1.1 percent decrease (West South Central urban region) to a high of 5.9 percent increase (West North Central rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (3.1 percent, a 3.9 percent increase from the effects of all other changes and a 0.8 percent decrease due to Federal rate changes). Payments to voluntary hospitals will increase 1.9 percent (a 3.3 percent increase from the effects of all other changes and a 1.4 percent decrease due to Federal rate changes), and payments to proprietary hospitals will increase 1.1 percent (a 3.1 percent increase from the effects of all other changes and a 2.0 percent decrease due to Federal rate changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both and for purposes of DSH, for FY 1999–2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2000 compared to the effects of reclassification for FY 1999, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2000 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2000 as a whole are projected to experience a 2.8 percent increase in payments (a 3.1 percent increase attributable to the effects of all other changes and a 0.3 percent decrease attributable to Federal rate changes). Payments to nonreclassified hospitals will increase slightly less (1.9 percent) than reclassified hospitals (2.8 percent) overall. Payments to nonreclassified hospitals will decrease more than reclassified hospitals from the Federal rate changes (1.5 percent compared to 0.3 percent), but they will gain about the same from the effects of all other changes (3.4 percent compared to 3.1 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1999 Compared to FY 2000]

	Number of hospitals	Average FY 1999 payments/case	Average FY 2000 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	4,834	632	645	1.9	−1.4
Large urban areas (populations over 1 million)	1,531	731	742	1.5	−1.8
Other urban areas (populations of 1 million or fewer)	1,146	622	636	2.3	−1.3
Rural areas	2,157	426	438	2.8	−0.4
Urban hospitals	2,677	684	697	1.8	−1.6
0–99 beds	650	501	507	1.1	−1.6
100–199 beds	912	602	609	1.2	−1.5
200–299 beds	553	660	673	2.0	−1.6
300–499 beds	423	704	720	2.3	−1.5
500 or more beds	139	892	906	1.5	−1.9
Rural hospitals	2,157	426	438	2.8	−0.4
0–49 beds	1,190	346	359	3.9	0.2
50–99 beds	580	400	413	3.4	−0.1
100–149 beds	232	439	451	2.7	−0.4
150–199 beds	85	459	479	4.3	−0.4
200 or more beds	70	549	550	0.1	−1.1
By Region:					
Urban by Region	2,677	684	697	1.8	−1.6
New England	148	693	715	3.1	−1.0
Middle Atlantic	412	751	759	1.1	−2.2
South Atlantic	399	671	692	3.1	−1.0
East North Central	444	645	663	2.7	−0.9
East South Central	154	642	662	3.1	−1.3
West North Central	179	664	672	1.3	−1.8
West South Central	331	664	657	−1.1	−2.9
Mountain	123	657	667	1.6	−1.2
Pacific	440	762	773	1.5	−1.9
Puerto Rico	47	298	295	−1.0	−1.4

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1999 Compared to FY 2000]

	Number of hospitals	Average FY 1999 payments/case	Average FY 2000 payments/case	All changes	Portion attributable to Federal rate change
Rural by Region	2,157	426	438	2.8	−0.4
New England	52	507	515	1.6	−0.6
Middle Atlantic	80	446	458	2.7	−1.3
South Atlantic	285	439	451	2.6	−0.4
East North Central	300	441	449	1.8	−0.4
East South Central	270	391	403	3.2	0.4
West North Central	490	417	442	5.9	0.6
West South Central	337	380	381	0.3	−1.7
Mountain	200	447	466	4.3	0.5
Pacific	138	498	512	2.8	−0.7
By Payment Classification:					
All hospitals	4,834	632	645	1.9	−1.4
Large urban areas (populations over 1 million)	1,607	724	735	1.5	−1.8
Other urban areas (populations of 1 million or fewer)	1,147	620	635	2.3	−1.3
Rural areas	2,080	423	435	2.9	−0.4
Teaching Status:					
Non-teaching	3,732	532	541	1.7	−1.2
Fewer than 100 Residents	868	664	679	2.1	−1.6
100 or more Residents	234	946	967	2.2	−1.8
Urban DSH:					
100 or more beds	1,362	724	737	1.8	−1.6
Less than 100 beds	84	505	500	−0.9	−1.2
Rural DSH:					
Sole Community (SCH/EACH)	153	390	418	7.3	0.1
Referral Center (RRC/EACH)	55	484	492	1.8	−0.5
Other Rural:					
100 or more beds	57	392	396	1.1	−0.6
Less than 100 beds	109	331	348	5.3	1.4
Urban teaching and DSH:					
Both teaching and DSH	703	794	811	2.1	−1.7
Teaching and no DSH	337	681	696	2.2	−1.6
No teaching and DSH	743	607	614	1.3	−1.5
No teaching and no DSH	971	573	580	1.3	−1.5
Rural Hospital Types:					
Non special status hospitals	881	378	387	2.6	−0.4
RRC/EACH	151	490	500	1.9	−0.9
SCH/EACH	638	428	446	4.4	0.0
Medicare-dependent hospitals (MDH)	352	345	357	3.5	0.0
SCH, RRC and EACH	58	498	511	2.4	0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY1999 and FY2000:					
Reclassified During Both FY1999 and FY2000	373	553	561	1.3	−1.3
Reclassified During FY2000 Only	131	594	642	8.1	3.1
Reclassified During FY1999 Only	136	531	513	−3.4	−6.3
FY2000 Reclassifications:					
All Reclassified Hospitals	504	562	578	2.8	−0.3
All Nonreclassified Hospitals	4,304	642	654	1.9	−1.5
All Urban Reclassified Hospitals	85	751	775	3.2	−1.1
Urban Nonreclassified Hospitals	2,592	682	694	1.7	−1.6
All Reclassified Rural Hospitals	419	489	502	2.6	0.1
Rural Nonreclassified Hospitals	1,712	381	394	3.4	−0.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	26	463	429	−7.3	−8.8
Type of Ownership:					
Voluntary	2,826	646	658	1.9	−1.4
Proprietary	721	634	641	1.1	−2.0
Government	1,255	555	572	3.1	−0.8
Medicare Utilization as a Percent of Inpatient Days:					
0–25	360	768	789	2.8	−2.1
25–50	1,739	726	737	1.5	−1.7
50–65	1,885	575	588	2.2	−1.2

Appendix B: Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 6 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this proposed rule: the December 31, 1998 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), and PPS–XIV (cost reporting periods beginning in FY 1997). In addition, to model payments, we use the January 1, 1999 update of the provider-specific file, and the March 1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently not paid under the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 1999 hospital-specific rates using the provider-specific file and the intermediary audit file. (We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Neither File	1
Audit File only	53
Provider-Specific File Only	103
Provider-Specific and Audit File	4717
Total	4874

Sixty-three of the 4,874 hospitals had unusable or missing data, or had no cost reports available. For 21 of the 63 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 21 hospitals in the analysis. We were able to estimate hospital-specific amounts from the PPS–IX cost report data for an additional 2 hospitals. Hence, we were able to use 23 of the 63 hospitals. We used 4,834 hospitals for the analysis. Forty hospitals could not be used in the analysis because of insufficient information. These hospitals account for less than 0.2 percent of admissions. Therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size (greater than ±20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should decrease as assets become fully depreciated and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the first two groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with the greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution, allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution, allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed size for large hospitals. We found the probability somewhat dependent on the prior year change in bed size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed size for large hospitals, we first projected changes in bed size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1998 (the MedPAR data year) and later, we use the number of discharges from the MEDPAR data. Some hospitals have considerably more discharges in FY 1998 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge, since fixed

costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 1998 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 1998 MedPAR file using the proposed FY 2000 DRG relative weights included in section VI. of the Addendum to this proposed rule. The case-mix index is increased each year after FY 1998 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will increase 0.5 percent in FY 1999 and 0.5 percent in FY 2000. (Since we are using FY 1998 cases for our analysis, the FY 1998 increase in case mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 1999, the budget neutrality adjustment factors were 1.00294 for the national rate and 1.00233 for the Puerto Rico rate.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 since the geographic adjustment factor for Puerto Rico was implemented in 1998.

To determine the factors for FY 2000, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2000 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 1999 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1999 relative weights and the FY 2000 geographic adjustment factor. In making the comparison, we held the FY 2000 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. We determined that, to achieve budget neutrality for the changes in the national geographic adjustment factor, an incremental budget neutrality adjustment of 0.99845 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00294, yielding a cumulative adjustment of 1.00139 through FY 2000. For the Puerto Rico geographic adjustment factor, an incremental budget neutrality adjustment of 1.00151 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00233, yielding a cumulative adjustment of 1.00384 through FY 2000. We apply these new adjustments, then compare estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 2000 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2000 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00014 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through FY 2000 would be 1.00153 nationally, and 1.00398 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992				1.00000				
1993			0.99800	0.99800				
1994			1.00531	1.00330				
1995			0.99980	1.00310				
1996			0.99940	1.00250				
1997			0.99873	1.00123				
1998			0.99892	1.00015				1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99845	1.00014	0.99859	1.00153	1.00151	1.00014	1.00165	1.00398

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for FYs 1992 through 1999, the proposed factors for FY 2000, and the estimated factors that would be applicable through FY 2004. We caution that these are estimates for FYs 2000 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy changes. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00153 (1.00398 for Puerto Rico) for FY 2000 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2000.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier) reduction
1992	N/A	0.9813	0.9602	.....	.9497	.....	415.59
1993	6.07	.9756	.9162	.9980	.9496	.....	417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2] .9260	378.34
1995	3.44	.9734	.8432	.9998	.9414	.....	376.83
1996	1.20	.9849	N/A	.9994	.9536	[3] .9972	461.96
1997	0.70	.9358	N/A	.9987	.9481	.....	438.92
1998	0.90	.9659	N/A	.9989	.9382	[4] .8222	371.51
1999	0.10	.9783	N/A	1.0028	.9392	.....	378.10
2000	−0.60	.9752	N/A	.9986	.9397	.....	374.31
2001	0.50	.9645	N/A	[5] 1.0000	[5] .9397	.....	372.06
2002	0.50	[6] 1.0000	N/A	1.0000	.9397	.....	387.68
2003	0.50	[6] 1.0000	N/A	1.0000	.9397	[4] 1.0255	399.57
2004	0.60	[6] 1.0000	N/A	1.0000	.9397	.....	401.97

[1] Note: The incremental change over the previous year.
[2] Note: OBRA 1993 adjustment.
[3] Note: Adjustment for change in the transfer policy.
[4] Note: Balanced Budget Act of 1997 adjustment.
[5] Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.
[6] Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

Appendix C: Report to Congress

BILLING CODE 4120–01–P

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 1 1999

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2000 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates an update for all PPS hospitals equal to the market basket rate of increase (2.7 percent) minus 1.8 percentage points. However, based on the continuing decline in hospital operating costs and the related record levels of hospital Medicare and total operating profit margins, we recommend an update for hospitals in both large urban and other areas of zero percent.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection in order to maintain access to services for Medicare beneficiaries. Medicare-dependent small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection in order to maintain access to services for beneficiaries. As you know, SCHs and MDHs are PPS hospitals. However, SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate and MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. We also recommend an update of zero percent to the hospital-specific rate.

Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two thirds of the limit. The President's FY 2000 budget incorporates an increase to the TEFRA limit using 2.7 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase

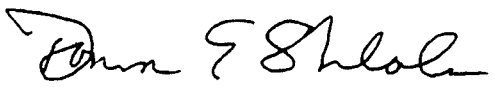
minus a percentage between 0 and 2.5 percentage points, or 0. Thus, we recommend an increase in the TEFRA limits of between 0 and 2.7 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2000 budget. A final recommendation on the appropriate percentage increases for FY 2000 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate the Health Care Financing Administration's analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any adjustment to the DRG weighting factors for FY 2000.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the President of the Senate.

Sincerely,



Donna E. Shalala

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 1 1999

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2000 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates an update for all PPS hospitals equal to the market basket rate of increase (2.7 percent) minus 1.8 percentage points. However, based on the continuing decline in hospital operating costs and the related record high levels of hospital Medicare and total operating profit margins, we recommend an update for hospitals in both large urban and other areas of zero percent.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection in order to maintain access to services for Medicare beneficiaries. Medicare-dependent small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection in order to maintain access to services for beneficiaries. As you know, SCHs and MDHs are PPS hospitals. However, SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate and MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. We also recommend an update of zero percent to the hospital-specific rate.

Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two thirds of the limit. The President's FY 2000 budget incorporates an increase to the TEFRA limit using 2.7 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase

minus a percentage between 0 and 2.5 percentage points, or 0. Thus, we recommend an increase in the TEFRA limits of between 0 and 2.7 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2000 budget. A final recommendation on the appropriate percentage increases for FY 2000 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate the Health Care Financing Administration's analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any adjustment to the DRG weighting factors for FY 2000.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives.

Sincerely,

Donna E. Shalala

BILLING CODE 4120–01–C

Appendix D: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 2000 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XV) of the Act sets the FY 2000 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.8 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2000 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.8 percentage points. Under section 1886(b)(3)(B)(ii) of the Act, the FY 2000 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket to 0 percent, depending on the hospital's costs in relation to its limit for the most recent cost reporting period for which information is available.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the first quarter 1999 forecast of the FY 2000 market basket increase of 2.7 percent for hospitals subject to the prospective payment system, the proposed updates to the standardized amounts are 0.9 percent (that is, the market basket rate of increase minus 1.8 percent percentage points) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to sole community and Medicare-dependent, small rural hospitals is also 0.9 percent. The proposed update for hospitals excluded from the prospective payment system would range from 0 percent to the percentage increase in the excluded hospital market basket (currently estimated at 2.6 percent).

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, this appendix provides the recommendations of appropriate update factors, the analysis underlying our recommendations, and our responses to the MedPAC recommendations concerning the update factors.

In its March 1, 1999 report, MedPAC stated that the legislated update of market basket increase minus 1.8 percentage points would provide a reasonable level of payment to hospitals. Although MedPAC suggests that a somewhat lower update could be justified in light of changes in the utilization and provision of hospital inpatient care, the Commission does not believe it is necessary to recommend a lower update for FY 2000. MedPAC did not make a separate recommendation for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals. We discuss MedPAC's recommendations concerning the update factors and our responses to these recommendations below.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that an appropriate update factor for the standardized amounts is 0.0 percentage points for hospitals located in large urban and other areas. We are also recommending an update of 0.0 percentage points to the hospital-specific rate for sole community hospitals and Medicare-dependent, small rural hospitals. These figures are consistent with the President's FY 2000 budget recommendations. We believe these recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund. When the President's budget was submitted, the market basket rate of increase was projected at 2.7 percent. This proposed recommendation is based on a more recent forecast of the market basket, although still 2.7 percent.

We recommend that hospitals excluded from the prospective payment system receive an update of between 0 and 2.6 percentage points. The update for excluded hospitals and units is equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percentage points, depending on the hospital's or unit's costs in relation to its rate-of-increase limit. The market basket rate of increase is currently forecast at 2.6 percent. This recommendation is consistent with the President's FY 2000 budget, although we note that the market basket rate of increase was forecast at 2.7 percent when the budget was submitted.

As required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of MedPAC in setting these recommended update factors. Our responses to the MedPAC recommendations concerning the update factors are discussed below.

III. MedPAC Recommendations for Updating the Prospective Payment System Standardized Amounts

For FY 2000, MedPAC's update framework would support an update to the standardized amounts under the prospective payment system between the increase in the hospital market basket minus 2.5 percentage points and the increase in the hospital market basket plus 0.1 percentage points. MedPAC notes that hospital total revenue margins have continued to increase this decade and the percentage of hospitals with negative total revenue margins remains much lower than it was a decade ago. Thus, MedPAC believes the statutory update of market basket increase minus 1.8 percentage points for FY 2000 is reasonable and appropriate.

MedPAC's estimate of the market basket increase is 2.3 percent, based on the fourth quarter 1998 estimate. MedPAC's market basket estimate focuses on employee compensation changes in the hospital industry and the economy in general, while HCFA's market basket forecast gives less weight to the projected changes in the hospital industry's wages. When MedPAC published its recommendations, HCFA's market basket forecast was 2.5 percent. Thus, MedPAC's update framework reflects a 0.2 percent adjustment for this difference.

Response: Our update recommendation of 0.0 percent is within the range of updates MedPAC has suggested for the prospective payment system hospitals, albeit at the low end. Our recommendation is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix:

a. *Productivity.* Service level productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use a labor productivity measure since this update framework applies to operating payment. To recognize that we are apportioning the short run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure for operating costs by the share of direct labor services in the market basket rate of increase to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989, or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Since it is not possible at this time to develop a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with

a 0.3 to 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of labor in total operating inputs, as calculated in the hospital market basket rate of increase. This method estimates an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years that output growth is relatively low and larger in years that output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality enhancing intensity growth, and net of expected decline in intensity due to reduction of cost ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply the sum of the expected change in intensity (0.0 percent), projected admissions change (1.0 percent for FY 2000), and projected real case-mix growth (0.5 percent), or 1.5 percent. The share of direct labor services in the market basket rate of increase (consisting of wages, salaries, and employee benefits) is 61.4 percent.

Multiplying the expected change in total hospital service output (1.5 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.4, provides our productivity standard of 0.3 percent, thus our recommendation includes a −0.3 percent update for improved productivity.

In past years, MedPAC's recommendation has taken into account product change. This year, while there is not a specific mention of product change in MedPAC's recommendation, similar factors do appear in their discussion of ''site of service substitution.'' HCFA takes this factor into account when measuring change in intensity, as discussed below. In addition, MedPAC's update framework contains a productivity adjustment of between −1.0 to 0.0 percent, which is slightly more optimistic than our estimate.

b. *Intensity*. We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 2000, we recommend an adjustment of 0.0 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level of quality-enhancing technology changes. A study published in the Winter 1992 issue of the *Health Care Financing Review*, ''Contributions of case mix and intensity change to hospital cost increases'' (pp. 151–163), suggests that one-third of the intensity change is attributable to high-cost technology. The balance was unexplained but the authors speculated that it is attributable to fixed costs in service delivery.

Typically, a specific new technology increases cost in some uses and decreases cost in other uses. Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost increasing effects for individual technologies and new technologies.

All things being equal, per-discharge fixed costs tend to fluctuate in inverse proportion to changes in volume. Fixed costs exist whether patients are treated or not. If volume is declining, per-discharge fixed costs will rise, but the reverse is true if volume is increasing.

Following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FYs 1994 through 1998 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the Medical CPI hospital component and changes in real case mix. Thus, in order to measure changes in intensity, one must measure changes in real case mix.

For FYs 1994 through 1998, observed case-mix index change ranged from a low of −.04 percent to a high of 1.7 percent, with a 5-year average change of 1.0 percent. Based on evidence from past studies of case-mix change, we estimate that real case-mix change fluctuates between 1.0 and 1.4 percent and the observed values generally fall in this range, although some years the figures fall outside this range. The average percentage change in charge per discharge was 2.9 percent and the average annual change in the medical CPI was 4.6 percent. Dividing the change in charge per discharge by the quantity of the real case-mix index change and the medical CPI, yields an average annual change in intensity of −2.9 percent. Assuming the technology/fixed cost ratio still holds, technology would account for a −1.0 percent annual decline while fixed costs would account for a −1.9 percent annual decline. The decline in fixed costs per discharge makes intuitive sense as volume, measured by total discharges, has increased during the period. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 2000.

MedPAC does not make an intensity recommendation per se, but its recommendation for the FY 2000 update includes two categories that we consider to be comparable with our intensity recommendation. MedPAC is recommending a 0.5 to 1.0 update for scientific and technological advances to account for increased costs of systems conversions necessary for computer compliance on January 1, 2000. MedPAC's recommendation also takes into account the increasingly apparent trend of some acute care providers to shift care to a postacute care facility. While this can occur for many reasons, there is good reason to suspect prospective payment system payment limits. Accordingly, MedPAC recommends an adjustment of −1.8 to −0.9 for site-of-care substitution.

As we mentioned in last year's final rule, higher input prices that hospitals incur to convert computer systems to be complaint on January 1, 2000, will be accounted for through the market basket. We agree with MedPAC that the site of care substitution effect is real and believe that it is factored into our intensity recommendation.

c. *Change in Case-Mix*. Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 2000 update recommendation, we are projecting a 0.5 percent increase in the case-mix index. Unlike in past years, where we differentiated between ''real'' case-mix increase and increases attributable to changes in coding behavior, we do not feel changes in coding behavior will impact the overall case-mix in FY 2000. As such, we project the entire change will be ''real.''

MedPAC also does not expect any case-mix change due to coding changes. MedPAC's estimate of overall case-mix change ranges from 0.0 to 0.2 percentage points for FY 2000.

d. *Effect of FY 1998 DRG Reclassification and Recalibration*. We estimate that DRG reclassification and recalibration for FY 1998 resulted in a 0.7 percent decrease in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER. MedPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation.

We make a forecast error correction if the actual market basket change for a previous fiscal year differs from the forecasted market basket by 0.25 percentage points or more. Our update framework for FY 2000 does not reflect a forecast error correction because, for FY 1998, there was less than a 0.25 percentage point difference between the actual market basket and the forecasted market basket.

TABLE 1.—COMPARISON OF FY 2000 UPDATE RECOMMENDATIONS

	HHS	MedPAC
Market Basket	MB	MB
Difference between HCFA & MedPAC Market Baskets		–0.4
Subtotal	MB	MB
Policy Adjustments Factors:		
Productivity	–0.3	–1.0 to 0.0
Site of Service Substitution	([3])	–1.8 to –0.9
Intensity	0.0.	
Science & Technology		0.5 to 1.0
Practice Patterns		([1])
Real Within DRG Change		([2])
Subtotal	–0.3	–2.3 to 0.1
Case-Mix Adjustment Factors:		
Projected Case-Mix Change	–0.5.	
Real Across DRG Change	0.5	0.0
Real Within DRG Change	([3])	0.0 to 0.2
Subtotal	0.0	0.0 to 0.2
Effect of 1998 Reclassification & Recalibration	–0.7.	
Forecast Error Correction	0.0	0.0
Total Recommended Update	MB –1.0	MB –2.7 to MB 0.1

[1] Included in MedPAC's Productivity Measure.
[2] Included in MedPAC's Case-Mix Adjustment.
[3] Included in HHS' Intensity Factor.

While the above analysis would support a recommendation that the update be no less than the market basket minus 1.0 percentage points, we are recommending an update of 0.0 percentage points. We note that had our framework included the negative intensity adjustment, the framework would have suggested an update in the range of market basket increase minus 3.9 percentage points and market basket increase minus 2.0 percentage points. However, consistent with past update recommendations, we did not make a negative adjustment for intensity this year. A negative intensity adjustment would capture the site of care substitution adjustment in MedPAC's recommendation. In conjunction with our Office of Actuary, we do intend to reexamine our update framework and the appropriateness of a negative intensity adjustment.

For FY 2000, we believe that a 0.0 update factor appropriately reflects current trends in health care delivery, including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. Our recommendation is within the range of MedPAC's recommendation. We also recommend that the hospital-specific rates applicable to sole community hospitals be increased by the same update, 0.0 percentage points.

IV. MedPAC Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units (Recommendation 4A)

For hospitals and units excluded from the prospective payment system, MedPAC's recommendation is that the Secretary ''should increase the market basket amount in the target amount update formula by 0.4 percentage points for fiscal year 2000.'' For cost reporting periods beginning in FY 2000, the statute provides that the update to the target amounts for excluded hospitals or units is equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percent, depending on the hospital's or unit's costs in relation to its target amount for the most recent cost reporting period for which information is available. MedPAC believes that the update formula for excluded hospitals should be adjusted upward by 0.4 percentage points, to reflect (1) a −0.1 percent adjustment for differences between HCFA's and MedPAC's market baskets and (2) a 0.5 percent adjustment for scientific and technological advances.

Response: We believe that the statutory update is adequate and that an upward adjustment to the statutory formula is unnecessary. Thus, we recommend that hospitals excluded from the prospective payment system receive an update between 0 percent and the increase in the market basket for excluded hospitals. Overall declines in inpatient operating costs and high levels of Medicare profit margins support our recommendation. We believe this update would ensure that Medicare acts as a prudent purchaser and would provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

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